HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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DOCKET NO. 16-0202-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant Sections 56-1013A and 56-1023, Idaho Code, Idaho Code, and.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law. Also, minor amendments were proposed for the text of the rule itself to bring it into alignment with changes in the Standards Manual approved in the 2012 Legislative Session.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 4, 2012, Idaho Administrative Bulletin, **Vol. 12-7, pages 44 through 47**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Wayne Denny at (208) 334-4000.

DATED this 21st day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2012.

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

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

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

Also, the text of the rule chapter needs some minor amendments to align it with changes in the Standards Manual approved by the 2012 Legislature.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because the content of the proposed updates to the EMS Physician Commission Standards Manual and to this chapter of rules already represents extensive input from stakeholders gathered during 2011 and early 2012.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2013-1, is being incorporated by reference into these rules to give it the force and effect of law and because republishing the document in the rule would be unduly cumbersome and expensive due to its length and format.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact

Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 8th day of June, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1201

004. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~2~~3-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at www.emspc.dhw.idaho.gov or from the EMS Bureau located at 650 W. State Street, Suite B-17, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ~~*(3-29-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. (3-29-10)

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. (3-29-10)

03. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. (3-29-10)

04. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: (3-29-10)

a. A designated physician is not present in the anticipated receiving health care facility; and (4-2-08)

b. The Nurse Practitioner, when designated, must have a preexisting written

agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

c. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and (4-2-08)

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. (4-2-08)

05. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of licensed EMS personnel. (3-29-10)

06. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual that is incorporated by reference under Section 004 of these rules. (3-29-10)

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must ~~*file*~~ submit the medical supervision plan~~, including identification of the EMS medical director and any designated clinicians~~ within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ~~(4-2-08)~~( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

~~**a**~~**b.** The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or ~~*the medical supervision plan*~~ of a change in the agency medical director within thirty (30) days of the change(s). ~~(4-2-08)~~( )

~~**b**~~**c.** The EMS Bureau must provide the Commission with the medical supervision plans ~~*annually and upon*~~ within thirty (30) days of request. ~~(4-2-08)~~( )

~~**c**~~**d.** The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. (3-29-10)

02. Level of Licensure Identification. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS licensure. (3-29-10)

03. Credentialing of Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and must submit the descriptions upon request of the Commission or the EMS Bureau. (3-29-10)

04. Notification of Employment or Utilization. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must report such employment or utilization to the EMS Bureau within thirty (30) days of engaging such activity. (3-29-10)

05. Designation of Supervising Physician. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic. (3-29-10)

06. Delegated Medical Supervision of EMS Personnel. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician. (3-29-10)

07. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The hospital supervising physician, or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: (3-29-10)

a. The Nurse Practitioner, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

b. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and (4-2-08)

c. The PA, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

d. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician. (4-2-08)

08. On-Site Contemporaneous Supervision. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician, or designated clinicians. (3-29-10)

09. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) ~~*upon*~~ within thirty (30) days of request ~~*of*~~ by the Commission or the EMS Bureau. ~~*(3-29-10)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-203, Idaho Code, and 7 CFR Part 273.1(c).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule regarding food stamp benefits for a child who resides in two households is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 287 and 288**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Rosie Andueza at (208) 334-5553.

DATED this 7th day of November, 2012.

Tamara Prisock
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450 W. State Street - 10th Floor
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e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **October 1, 2012**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-203, Idaho Code, and 7 CFR Part 273.1(c).

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

Tuesday - October 23, 2012 - 10 a.m. MDT

DHW Region IV Office
1720 N. Westgate Drive
Suite A, Room 131
Boise, ID 83704

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Currently, food stamp benefits for a child are given to the first parent who applies for benefits for the child regardless of the amount of time the child lives in the home. This rule change is necessary to provide a more equitable way of determining food stamp benefits for a child when both parents apply for food stamp benefits for the child, by giving the parent with the primary physical custody the food stamp benefit.

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

These rules confer a benefit to provide that a child receives his food stamp benefit in the home with the parent who has primary custody.

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

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

There is no fiscal impact to state general funds for this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule and was not feasible for the Department to negotiate the change.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Rosie Andueza at (208) 334-5553.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-1201

214. ~~*JOINT*~~ CHILD CUSTODY.

~~*In joint custody situations, children may move from one (1) parent's home to the other parent's home on a regular schedule during the month. If only one (1) parent applies, the child may be included in that parent's household. If both parents apply, they must be told no child can participate in two (2) Food Stamp households in the same month. The parents should decide which household will include the child. Where there are two (2) or more children, the children may be a member of either but not both households. If the parents cannot agree on the child's household for Food Stamps, include the child in the household of the first parent to apply. Assign the shortest allowable certification period.*~~ For a child who is under the age of eighteen (18), the parent who has primary physical custody is eligible to receive Food Stamp benefits for that child. If both parents request food stamp benefits for the child, primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a certification period. When only one (1) parent applies for food stamp benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child.

~~*(6-1-94)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and 7 CFR, Part 273.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules aligning the Food Stamp Program with state law and federal regulations are being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 289 through 294**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Rosie Andueza at (208) 334-5553.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
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(208) 334-5500 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **September 1, 2012**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and 7 CFR, Part 273.

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 October 17, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes align Idaho's Food Stamp Program with state law and federal regulations. The changes also support operational changes being made in the administration of the Food Stamp Program. The term “guide dog” has been changed to “service animal.” Clarification for a spouse has been updated to remove reference to “common law marriage” that is no longer recognized in Idaho. To support operational changes, clarification has been made to update the application process requirements for screening of an applicant, and removing the requirement that an applicant apply at the office serving the area where the applicant resides.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to bring the Idaho Food Stamp program rules into compliance by aligning these rules with both federal regulations and state law.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule and was not feasible for the

Department to negotiate the change.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Rosie Andueza at (208) 334-5553.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-1202

012. DEFINITIONS M THROUGH Z.
For the Food Stamp Program, the following definitions apply: (4-11-06)

01. Migrant Farmworker Household. A migrant farmworker household has a member who travels from community to community to do agricultural work. (4-6-05)

02. Minimum Utility Allowance (MUA). Utility deduction given to a food stamp household that has a cost for one (1) utility that is not heating, cooling, or telephone. (3-29-10)

03. Nonexempt. A household member who must register for and participate in the JSAP program. A household member who must register for work. (6-1-94)

04. Nonprofit Meal Delivery Service. A political subdivision or a private nonprofit organization, which prepares and delivers meals, authorized to accept Food Stamps. (6-1-94)

05. Overissuance. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. (6-1-94)

06. Parental Control. Parental control means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. Minors, emancipated through marriage, are not under parental control. Minors living with children of their own are not under parental control. (4-6-05)

07. Participant. A person who receives Food Stamp benefits. (4-6-05)

08. Program. The Food Stamp Program created under the Food Stamp Act and

administered in Idaho by the Department. (6-1-94)

09. Public Assistance. Public assistance means Temporary Assistance for Families in Idaho (TAFI), and Aid to the Aged, Blind, and Disabled (AABD). (4-6-05)

10. Recertification. A recertification is a process for determining ongoing eligibility for Food Stamps. (4-11-06)

11. Retail Food Store. A retail food store, for Food Stamp purposes means: (6-1-94)

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. (6-1-94)

b. Public or private communal dining facilities and meal delivery services. (6-1-94)

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. (6-1-94)

d. Public or private nonprofit group living arrangements. (6-1-94)

e. Public or private nonprofit shelters for battered women and children. (6-1-94)

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. (6-1-94)

g. A farmers' market. (6-1-94)

h. An approved public or private nonprofit establishment which feeds homeless persons. The establishment must be approved by FCS. (7-1-98)

12. Sanction. A penalty period when an individual is ineligible for Food Stamps. (3-30-07)

13. Seasonal Farmworker Household. A seasonal farmworker household has a member who does agricultural work of a seasonal or other temporary nature. (4-6-05)

14. Spouse. Persons who are ~~*living together,*~~ legally married ~~*or free to marry, and are holding themselves out as man and wife*~~ under Idaho law. ~~*(4-6-05)*~~( )

15. Standard Utility Allowance (SUA). Utility deduction given to a food stamp household that has a cost for heating or cooling. (4-11-06)

16. State. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands and the Virgin Islands of the United States. (6-1-94)

17. State Agency. The Idaho Department of Health and Welfare. (6-1-94)

18. Student. An individual between the ages of eighteen (18) and fifty (50), physically and intellectually fit, and enrolled at least half-time in an institution of higher education. (6-1-94)

19. Supplemental Security Income (SSI). Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. (4-11-06)

20. Systematic Alien Verification for Entitlements (SAVE). The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. (4-11-06)

21. Telephone Utility Allowance (TUA). Utility deduction given to a Food Stamp household that has a cost for telephone services and no other utilities. (3-29-10)

22. Timely Notice. Notice that is mailed via the U. S. Postal Service, or electronically, at least ten (10) days before the effective date of an action taken by the Department. (3-29-12)

23. Twelve Month Contact. For households that have a twenty-four (24) month certification period, Department staff contact the household during the twelfth month of the certification period for the purpose of determining continued eligibility. (4-6-05)

24. Tribal General Assistance. Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. This cash is intended to promote the health and well-being of recipients. (4-11-06)

25. Verification. The proof obtained to establish the accuracy of information and the household's eligibility. (6-1-94)

26. Verified Upon Receipt. Food stamp benefits are adjusted on open food stamp cases when information is received from "verified upon receipt" sources. Information "verified upon receipt" is received from a manual query or automated system match with the Social Security Administration or Homeland Security query for citizenship status. (3-30-07)

27. Written Notice. Correspondence that is generated by any method including handwritten, typed, or electronic, delivered to the customer by hand, U.S. Mail, professional delivery service, or by any electronic means. The terms "notice" and "written notice" are used interchangeably. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

~~***108. WRONG FIELD OFFICE CONTACTED.***~~
~~*If a household contacts the wrong Field Office, the Department will give the household the address and phone number of the correct Field Office. The Department will offer to forward the AFA to the correct Field Office, and tell the household the AFA is not filed and processing standards do not start until the AFA gets to the correct field office. The AFA must contain the applicant's name, address, signature and date of application. The AFA must be date stamped and*~~

~~*mailed to the correct Field Office the same day, or delivered to the correct Field Office the next day.* (3-15-02)~~

~~***109. AFA MAILED TO WRONG FIELD OFFICE.***~~
~~*If the AFA was mailed to the wrong Field Office, the Department will mail the AFA to the correct Field Office. The AFA must be mailed to the correct Field Office the same day it is received.* (6-1-94)~~

108. -- 109. (RESERVED)

110. APPLICANTS WHO MOVE OUT OF IDAHO.
~~*When a Food Stamp applicant moves within Idaho, the sending and receiving Field Offices must act to transfer the case and change the address.* (4-11-06)~~

~~***01. Duties of Sending Field Office**. If an applicant household is moving and submits its application to a Field Office other than the one serving the area where it is moving, the sending office must transfer the case. Duties of the sending Field Office are:* (6-1-94)~~

~~***a.** Give household new field office information. The sending Field Office must give the household the address and telephone number of the correct Field Office.* (6-1-94)~~

~~***b.** Forward application. The sending Field Office must offer to forward the application and case record to the proper Field Office. The application and case record must be sent the same day the contact is made with the wrong Field Office.* (6-1-94)~~

~~***c.** Inform applicant. The sending Field Office must tell the household its application has been filed and will be forwarded to the proper Field Office.* (6-1-94)~~

~~***d.** Mail application same day as received. If the application was mailed to the wrong Field Office, it must be mailed to the proper Field Office the same day it is received.* (6-1-94)~~

~~***02. Duties of Receiving Field Office**. The receiving Field Office must schedule an interview with the applicant household. The interview may be face-to-face, by telephone or by home visit. The application must be approved or denied within the specified time limits.* (6-1-94)~~

~~***03. Duties When Applicant Moves Out of Idaho**.~~ If all members of a Food Stamp applicant household move outside of Idaho, determine eligibility for the month(s) in which they resided in Idaho, as long as duplicate participation in another state does not occur. Close the case effective the end of the month in which the household moves out of Idaho. A closure notice is not required. ~~(4-11-06)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

155. EXPEDITED SERVICE ELIGIBILITY.
~~*Application forms*~~ Applicants must be screened to determine if the household is entitled to

expedited service. The household must meet one (1) of the expedited service criteria below. The household must have provided proof postponed by the last expedited service or have been certified under the normal standards since the last expedited service. ~~*(6-1-94)*~~( )

01. Low Income and Resources. To receive expedited services the household's monthly countable gross income must be less than one hundred fifty dollars ($150) and the household's liquid resources must not exceed one hundred dollars ($100). (6-1-94)

02. Destitute. To receive destitute expedited services the household must be a destitute migrant or seasonal farmworker household. The household's liquid resources must not exceed one hundred dollars ($100). (7-1-97)

03. Income Less Than Rent and Utilities. The household's combined monthly gross income and liquid resources are less than their monthly rent, or mortgage, and utilities cost. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

535. MEDICAL EXPENSES.
Medical expenses over thirty-five dollars ($35), for elderly or disabled household members, are deducted from the household income. Allowable medical expense deductions are listed in Subsection 535.01 through 535.14 of these rules. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. (3-30-07)

01. Medical and Dental Services. Services must be performed by licensed practitioners, physicians, dentists, podiatrists, or other qualified health professionals. Other qualified health professionals include registered nurses, nurse practitioners, licensed physical therapists and licensed chiropractors. (6-1-94)

02. Psychotherapy and Rehabilitation Services. Services must be performed by licensed psychiatrists, licensed clinical psychologists, licensed practitioners, physicians or other qualified health professionals. (6-1-94)

03. Hospital or Outpatient Treatment. Hospital or outpatient treatment includes expenses for hospital, nursing care, State licensed nursing home care, and care to a person immediately before entering a hospital or nursing home. (4-6-05)

04. Prescription Drugs. Prescription drugs and prescribed over-the-counter medication including insulin. (6-1-94)

05. Medical Supplies and Sickroom Equipment. Medical supplies and sickroom equipment including rental or other equipment. (6-1-94)

06. Health Insurance. Health and hospitalization insurance premiums. These do not include health and accident policies payable in a lump sum for death or dismemberment. These do

not include income maintenance policies to make mortgage or loan payments while a beneficiary is disabled. (6-1-94)

07. Medicare Premiums. Medicare premiums related to coverage under Title XVIII of the Social Security Act. (6-1-94)

08. Cost-Sharing or Spend-Down Expenses. Cost-sharing or spend-down expenses incurred by Medicaid recipients. (6-1-94)

09. Artificial Devices. Dentures, hearing aids, and prostheses. (6-1-94)

10. ~~*Guide Dog*~~ Service Animal. Expenses incurred buying and caring for any animal ~~*trained and routinely used to help*~~ that has received special training to provide service to a disabled person. Expenses include costs for ~~*dog*~~ the service animal's food, training, and veterinar~~*ian*~~y services. ~~*(4-6-05)*~~( )

11. Eyeglasses. Expenses for eye examinations and prescribed eyeglasses. (4-6-05)

12. Transportation and Lodging. Reasonable transportation and lodging expenses incurred to get medical services. (4-6-05)

13. Attendant Care. Attendant care costs necessary due to age, disability, or illness. If attendant care costs qualify for both the excess medical and dependent care expense deductions, the cost is treated as a medical expense. (4-6-05)

14. Attendant Meals. An amount equal to the maximum Food Stamp allotment for a one (1) person household per month is deducted if the household provides most of the attendant's meals. (3-29-10)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2013**. This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code.

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

The Department is aligning the asset transfer penalties for Medicaid applicants under the home and community based services (HCBS) with applicants who reside in a nursing facility. By providing this benefit to HCBS applicants, the disparity between the Nursing Home and Home Community Based Services (HCBS) participants will be removed. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 295 and 296**.

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

This rule change confers a benefit to Home and Community Based Services (HCBS) participants that previously was not available under these rules.

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

The Department considers this rule change to be cost neutral. The intent of this change is for eligible participants to receive the most cost-effective level of service and to be able to stay in the community rather than be forced into a nursing facility.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule or temporary rule, contact Shannon Epperley at (208) 334-5969.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Friday - October 12, 2012 - 10:00 a.m. MDT

DHW Region IV Office
1720 N. Westgate Drive
Suite A, Room 131
Boise, ID 83704

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In response to a petition for rulemaking from the Trust and Estate Professionals of Idaho (TEPI), the Department is amending these rules to align the asset transfer penalties for Medicaid applicants under the home and community based services (HCBS) with those applicants who reside in a nursing facility. By allowing HCBS applicants to have an asset transfer penalty period implemented, will remove the disparity between the Nursing Home and Home Community Based Services (HCBS) participants.

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

described herein: None.

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

The Department considers this rule change to be cost neutral. The intent of this change is for eligible participants to receive the most cost-effective level of service and to be able to stay in the community rather than be forced into a nursing facility.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the March 7, 2012, Idaho Administrative Bulletin, **Vol. 12-3, page 29**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Shannon Epperley at (208) 334-5969.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1201

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the time of the transfer for all of the assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. The penalty period for asset transfers is applied as follows: (3-30-07)

01. Penalty Period for Transfer Prior to February 8, 2006. For assets transferred prior to February 8, 2006, there is no penalty if the amount transferred is less than the cost of one (1) month's care. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months. A penalty period is computed for each transfer. A penalty period must expire before the next begins. Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of consecutive penalty periods is dropped. (3-30-07)

02. Penalty Period for Transfers On or After February 8, 2006. For assets

transferred on or after February 8, 2006, the penalty period begins running the first day of the month after the month the transfer took place or was discovered to have taken place, or the date the individual would have been eligible for long-term care services or HCBS, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends.

~~*(3-30-07)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

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

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rules amending future cost of living allowance increases are being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 297 through 299**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Shannon Epperley at (208) 334-5969.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Monday, October 22, 2012 **1 p.m. MDT**
DHW Region IV Office **1720 N. Westgate Drive** **Suite A, Room 131** **Boise, ID 83704**

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended to provide a more equitable division of future cost of living allowance (COLA) increases between the participant's personal needs allowance (PNA) and the rent, utilities, and food (RUF). This will be done by increasing both the PNA and the RUF by the percentage of the COLA increase.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted nor feasible because at a stakeholder meeting held on May 3, 2012, discussions among those in attendance on the distribution of yearly cost-of-living adjustments did not arrive at consensus. The Department did not feel further negotiations would result in an agreement or consensus on the issue.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed

rule, contact Shannon Epperley at (208) 334-5969.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1202

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person he lives with who is not his parent, child or sibling. (3-30-07)

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning ~~*January 1, 2007*~~ July 1, 2013, the Room and Board allowance will be adjusted annually by ~~*eighty percent (80%)*~~ the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded ~~*up*~~ to the next dollar. ~~*(3-30-07)*~~( )

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning ~~*January 1, 2007*~~ July 1, 2013, this basic allowance will be adjusted annually by ~~*twenty percent (20%)*~~ the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded ~~*down*~~ to the nearest dollar.
~~*(3-30-07)*~~( )

513. RESIDENTIAL CARE OR ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential Care or Assisted Living Facility (RALF), in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," or a Certified Family Home (CFH), in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," is budgeted a basic allowance of seventy-seven dollars ($77) monthly. Beginning ~~*January 1, 2007*~~ July 1, 2013, this basic allowance will be adjusted annually by ~~*twenty percent (20%)*~~ the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded ~~*down*~~ to the nearest dollar. ~~*(3-30-07)*~~( )

01. Budgeted Monthly Allowance Based On Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant does not require State Plan Personal Care Services (PCS), his

eligibility and allowances are based on the Room and Board rate in Section 512 of these rules.
(4-7-11)

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules. Beginning ~~*January 1, 2007*~~ July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by ~~*eighty percent (80%)*~~ the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded ~~*up*~~ to the next dollar.

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules. Beginning ~~*January 1, 2007*~~ July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by ~~*eighty percent (80%)*~~ the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded ~~*up*~~ to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06

	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

~~*(3-30-07)*~~( )

03. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH State Plan PCS allowances. He may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption.
(3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b), 56-203(7), 56-203(9), 56-209(g), 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, as amended in House Bill 260.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The proposed rules provided the administration and policies needed to implement reimbursement changes made in statute. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the **December 7, 2011, Idaho Administrative Bulletin, Vol. 11-12, pages 59 through 61**.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: The 2011 Legislature adopted House Bill 260 which identified and implemented state general fund savings associated with this rulemaking. These savings were included in the Department's appropriation budgets for the current state fiscal year.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 4th day of May, 2012.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **September 28, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(7), 56-203(9), 56-209(g), 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, as amended in House Bill 260.

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 December 21, 2011.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Section 56-209(g), Idaho Code, the Department is required to pay the lesser of the pharmacy provider's lowest charge to the general public for a drug or the estimated acquisition cost (EAC), plus a dispensing fee. These changes provide for the administration and policies needed to implement the reimbursement to pharmacies required in statute. Obsolete language is being removed and the structure for dispensing fees is being added based on a tiered structure.

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

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

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

The state general fund savings associated with this rulemaking are estimated to be $2,000,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated

rulemaking was conducted to implement Section 8 of HB 260 regarding pharmacy drug acquisition costs and dispensing fees. The notice of negotiated rulemaking was published in the **May 4, 2011, Idaho Administrative Bulletin, Vol. 11-5, page 62**.

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

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before December 28, 2011.

DATED this 8th day of November, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1101

665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.

~~***01. Nonpayment of Prescriptions.***~~ Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. ~~*(3-30-07)*~~

~~***02. Payment Procedures.***~~ The following protocol must be followed for proper reimbursement. ~~*(3-30-07)*~~( )

~~*a*~~**01. Filing Claims**. Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program. Pharmacists must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form must include information described in the pharmacy guidelines issued by the Department. ~~*(3-30-07)*~~( )

~~*b*~~**02. Claim Form Review**. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (3-30-07)

~~*c*~~**03. Billed Charges**. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (3-30-07)

~~*d*~~**04. Reimbursement**. Reimbursement to pharmacies is limited to the lowest of the

following: (3-30-07)

~~i~~**a.** Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (3-30-07)

~~ii~~**b.** State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (3-30-07)

~~iii~~**c.** Estimated Acquisition Cost (EAC), ~~*as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug*~~ defined as the Average Actual Acquisition Cost (AAAC), plus the assigned dispensing fee. In cases where no AAAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC will mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter; or ~~(4-7-11)~~( )

~~iv~~**d.** The pharmacy's ~~*usual and customary charge to the general public*~~ billed charges as defined in Subsection 665.02~~2~~**3**~~.c.~~ of this rule. ~~(3-30-07)~~( )

~~e~~**05. Dispensing Fee~~s~~.** Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: ~~(3-30-07)~~( )

~~i~~**a.** Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (3-30-07)

~~ii~~**b.** Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (3-30-07)

~~iii~~**c.** Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (3-30-07)

~~iv~~**d.** When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (3-30-07)

06. Claims Volume Survey for Tier-Based Dispensing Fees. The Department will survey pharmacy providers to establish a dispensing fee for each provider. The dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department no later than May 31st each year. Pharmacy providers who do not complete the annual claims volume survey will be assigned the lowest dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the dispensing fee is provided online at: http://healthandwelfare.idaho.govLinkClick.aspx?fileticket=iJDsiQavFLc%3d&tabid=119&mid=1111. ( )

***f*07. Remittance Advice**. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (3-30-07)

***g*08. Return of Drugs**. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows:(3-30-07)

***i*a.** A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (3-30-07)

***ii*b.** The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (3-30-07)

***iii*c.** The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (3-30-07)

0*3*9. Periodic State Cost Surveys. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Idaho Medicaid program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. *(4-7-11)*( )

10. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online at: http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=iJDsiQavFLc%3d&tabid=119&mid=1111. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-264, and 56-1610, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

This pending rule clarifying the Department's practice relating to estate recovery of life estate interests is being adopted as proposed. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 30 through 32**.

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

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lisa Hettinger at (208) 287-1141.

DATED this 25th day of October, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-264, and 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 19, 2012.

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 new rule change is being added to clarify the Department's current interpretation and practice relating to estate recovery of life estate interests after the death of a Medicaid participant. This rule change was requested by the Trust and Estate Professionals of Idaho (TEPI).

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

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

There is no fiscal impact due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the March 7, 2012, Idaho Administrative Bulletin, **Vol. 12-3, page 30**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lisa Hettinger at (208) 287-1141.

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 September 26, 2012.

DATED this 3rd day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1202

905. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

01. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. Recovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and, when applicable, as provided in Subsection 903.05 of these rules. No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. (4-7-11)

02. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim:(3-30-07)

a. Burial expenses, which include only those reasonably necessary for embalming, transportation of the body, cremation, flowers, clothing, and services of the funeral director and staff may be deducted. (3-30-07)

b. Other legally enforceable and necessary debts with priority may be deducted. The Department's claim is classified and paid as a debt with preference as defined in Section 15-03-805, Idaho Code. Debts of the deceased participant that may be deducted from the estate prior to satisfaction of the Department's claim must be legally enforceable debts given preference over the Department's claim under Section 15-03-805, Idaho Code. (3-30-07)

03. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. (3-30-07)

04. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (3-30-07)

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant or his or her spouse will not be subject to estate recovery if: ( )

a. Neither the Medicaid participant or his or her spouse ever owned the remainder interest; or ( )

b. The life estate was created prior to July 1, 1995. ( )

0~~5~~6. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement which separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (3-30-07)

0~~6~~7. Release of Estate Claims. The Department will release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: (3-30-07)

a. When an undue hardship waiver as defined in Subsection 905.07 of this rule has been granted; or (4-7-11)

b. When a written agreement with the authorized representative to pay the Department's claim in thirty-six (36) monthly payments or less has been achieved. (3-30-07)

0~~7~~8. Purpose of the Undue Hardship Exception. The undue hardship exception is intended to avoid the impoverishment of the deceased participant's family due to the Department exercising its estate recovery right. The fact that family members anticipate or expect an inheritance, or will be inconvenienced economically by the lack of an inheritance, is not cause for the Department to declare an undue hardship. (3-30-07)

0~~8~~9. Application for Undue Hardship Waiver. An applicant for an undue hardship waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (3-30-07)

~~09~~10. Basis for Undue Hardship Waiver. Undue hardship waivers will be considered in the following circumstances: (3-30-07)

a. The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or (3-30-07)

b. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (3-30-07)

c. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. (3-30-07)

d. The participant received medical assistance as the result of a crime committed against the participant. (3-30-07)

~~10~~11. Limitations on Undue Hardship Waiver. Any beneficiary of the estate of a

deceased participant may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to his death, or by his legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case by case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. (3-30-07)

~~1~~12. **Set Aside of Transfers**. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether or not the asset transfer resulted, or could have resulted, in a period of ineligibility. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1203

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also Title XIX (Medicaid) of the Social Security Act, Section 1905(bb)(2) and Section 56-209(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

A revision to Title XIX, Section 1905(bb)(2) of the Social Security Act requires all State Medicaid Programs to cover tobacco cessation products and counseling for pregnant women and children. The Department submitted Docket No. 16-0309-1201 to cover tobacco cessation products for pregnant women and align this chapter with the federal mandate. The rule was rejected by the 2012 Legislature because of concerns that it did not take into consideration the recommendations in "A Clinical Practice Guideline," published by the Public Health Service (PHS) in May 2008.

This guideline document recommends strategies to assist clinicians in identifying and treating tobacco dependency. Idaho already covers the recommended strategies such as counseling, but under the current rules pharmacologic interventions are not available to all Medicaid participants. The overview of the PHS clinical guidelines indicates that, ". . . although smoking cessation pharmaceuticals are not usually recommended for pregnant women, such use may be evaluated on a case-by-case basis, as determined by a woman and her physician."

The rule amendments proposed under this docket will allow for coverage of tobacco cessation products for pregnant women and children when their physician determines that the products are necessary and safe for the health of the participant and the baby in accordance with the PHS guideline document cited above. Failure to align these rules with federal law may put the Department's federal matching funds at risk.

The Department is also aligning these rules with the Idaho Medicaid State Plan, and with Medicaid's reimbursement methodology defined in Section 56-209(g), Idaho Code. This realignment will eliminate the reference to the "unit dose fee" for the dispensing of prescription medications.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 4, 2012, Idaho Administrative Bulletin, **Vol. 12-7, pages 48 through 52**.

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

It is anticipated that the cost of this change will be less than $1000. The tobacco cessation products are rarely recommended for pregnant women and children, and all products would require prior authorization. During the past calendar year there have been no requests for these products. There is no fiscal impact associated with the removal of the reference to "unit dose fee."

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Matt Wimmer at (208) 364-1989.

DATED this 4th day of October, 2012.

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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are **September 28, 2011, and March 29, 2012**.

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 by Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also Title XIX (Medicaid) of the Social Security Act, Section 1905(bb)(2), and Section 56-209(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 July 18, 2012.

The hearing site(s) will be accessible to persons with disabilities. Requests for

accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

A revision to Title XIX, Section 1905(bb)(2) of the Social Security Act requires all State Medicaid Programs to cover tobacco cessation products and counseling for pregnant women and children. The Department submitted Docket No. 16-0309-1201 to cover tobacco cessation products for pregnant women and align this chapter with the federal mandate. The rulemaking was rejected by the 2012 Legislature under HCR 44 which directed the Department to promulgate a rule that considers the recommendations in "A Clinical Practice Guideline," published by the Public Health Service (PHS) in May 2008.

The guidelines on tobacco cessation treatment referenced by the legislature recommends strategies to assist clinicians in identifying and treating tobacco dependency. Idaho already covers the recommended strategies such as counseling, but under the current rules pharmacologic interventions are not available to Medicaid participants. The overview of the PHS clinical guidelines indicates that, "... although smoking cessation pharmaceuticals are not usually recommended for pregnant women, such use may be evaluated on a case-by-case basis, as determined by a woman and her physician."

Currently Medicaid rules do not cover this specific circumstance. These rule amendments will allow for coverage of tobacco cessation products for pregnant women and children when their physician determines that the products are necessary and safe for the health of the participant and the baby. Failure to align these rules with federal law may put the Department's federal matching funds at risk.

The Department also needs to make a change in the same Section of rules (662) to bring the rules into alignment with the Idaho Medicaid State Plan, and with Medicaid's reimbursement methodology defined in Section 56-209(g), Idaho Code. This rule change eliminates the reference to the unit dose fee for the dispensing of prescription medications.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is being done to comply with deadlines in amendments to governing law or federal programs, in particular, Title XIX, Section 1905(bb)(2) of the Social Security Act and Section 56-209(g), Idaho Code.

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

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

It is anticipated that the cost of this change will be less than $1000. The tobacco cessation products are rarely recommended for pregnant women and children, and all products would

require prior authorization. During the past calendar year there have been no requests for these products. There is no fiscal impact associated with the removal of the reference to "unit dose fee."

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done in order to bring this chapter into compliance with Title XIX, Section 1905(bb)(2) of the Social Security Act and Section 56-209(g), Idaho Code. Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Matt Wimmer at (208) 364-1989.

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 July 25, 2012.

DATED this 12th day of June, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1203

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsection 662.04 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, as defined under Section 54-1705(28), Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. (3-30-07)

02. Dispensing Fee. Dispensing Fee is defined as the cost of filling a prescription including direct pharmacy overhead, ~~*and is one (1) of two (2) types*~~ and is for all services pertaining to the usual practice of pharmacy, including: ~~*(3-30-07)*~~( )

~~***a.*** *Regular Dose Fee. For services pertaining to the usual practice of pharmacy, including but not limited to:* *(3-30-07)*~~

~~*i*~~**a.** Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (3-30-07)

~~*ii*~~**b.** Participation in drug selection; (3-30-07)

~~iii~~**c.** Drug administration; (3-30-07)

~~iv~~**d.** Drug regimen and research reviews; (3-30-07)

~~v~~**e.** Proper storage of drugs; (3-30-07)

~~vi~~**f.** Maintenance of proper records; (3-30-07)

~~vii~~**g.** Prescriber interaction; and (3-30-07)

~~viii~~**h.** Patient counseling. (3-30-07)

~~***b.*** *Unit Dose Fee. Unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a twenty-four (24) hour supply in any participant's drug tray at any given time. These drug trays, which contain a twenty-four (24) hour supply of medication, must be delivered to the facility at a minimum of five (5) days per week.~~ ~~(3-30-07)~~

03. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: (3-30-07)

a. Days' Supply. Medicaid will not cover any days' supply of prescription drugs that exceeds the quantity or dosage allowed by these rules. (3-30-07)

b. Brand Name Drugs. Medicaid will not pay for a brand name product that is part of the federal upper limit (FUL) or state maximum allowable cost (SMAC) listing when the physician has not specified the brand name drug to be medically necessary. (3-30-07)

c. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (3-30-07)

d. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (3-30-07)

e. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (3-30-07)

04. Excluded Drug Products. The following categories and specific products are excluded from coverage by Medicaid: (3-30-07)

a. Non-Legend Medications. Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status unless: (3-30-07)

i. They are included in Subsection 662.05.b. of these rules; or (3-30-07)

ii. The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the Pharmacy And Therapeutics Committee. Therapeutically interchangeable is defined in Subsection 663.01.e. of these rules. (3-30-07)

b. Legend Drugs. Any legend drugs for which federal financial participation is not available. (3-30-07)

c. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Section 663 of these rules. (3-30-07)

d. Amphetamines and Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Section 663 of these rules. (3-30-07)

e. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (3-30-07)

f. Impotency Aids. Impotency aids, either as medication or prosthesis. (3-30-07)

g. Tobacco Cessation Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products, with the exception that both legend and non-legend tobacco cessation products will be covered for children and pregnant women when prescribed by their physician. ~~(3-30-07)~~( )

h. Medications Utilized for Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (3-30-07)

i. Vitamins. Vitamins unless included in Subsection 662.05.a. of these rules. (3-30-07)

j. Dual Eligibles. Drug classes covered under Medicare, Part D, for Medicaid participants who are also eligible for Medicare. (3-30-07)

05. Additional Covered Drug Products. Additional drug products will be allowed as follows: (3-30-07)

a. Therapeutic Vitamins. Therapeutic vitamins may include: (3-30-07)

i. Injectable vitamin B12 (cyanocobalamin and analogues); (3-30-07)

ii. Vitamin K and analogues; (3-30-07)

iii. Pediatric legend vitamin-fluoride preparations; (3-30-07)

iv. Legend prenatal vitamins for pregnant or lactating women; (3-30-07)

v. Legend folic acid; (3-30-07)

vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; ~~and~~ ~~(3-30-07)~~( )

vii. Legend vitamin D and analogues~~.~~; and ~~(3-30-07)~~( )

viii. Legend smoking cessation products for pregnant women and children. ( )

b. Prescriptions for Nonlegend Products. Prescriptions for nonlegend products may include: (3-30-07)

i. Insulin; (3-30-07)

ii. Disposable insulin syringes and needles; (3-30-07)

iii. Oral iron salts; ~~and~~ ~~(3-30-07)~~( )

iv. Permethrin~~.~~; and ~~(3-30-07)~~( )

v. Smoking cessation products for pregnant women and children. ( )

06. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (3-30-07)

a. Doses of Medication. Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (3-30-07)

i. Cardiac glycosides; (3-30-07)

ii. Thyroid replacement hormones; (3-30-07)

iii. Prenatal vitamins; (3-30-07)

iv. Nitroglycerin products - oral or sublingual; (3-30-07)

v. Fluoride and vitamin/fluoride combination products; and (3-30-07)

vi. Nonlegend oral iron salts. (3-30-07)

b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1204

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In 2011, the Idaho Legislature approved the Children's System Redesign. Under the redesign, the Department is moving from a one-size-fits-all system that was only able to deliver therapy, to a system that provides a continuum of care based on the child's level of need. The new array of benefits replaces developmental therapy and intensive behavioral intervention (IBI) services.

Removing developmental disabilities benefits from the State plan directly impacts the school-based service providers who deliver the same services. Rule changes are needed to incorporate replacement services for school-based providers when developmental therapy and IBI are no longer available starting July 1, 2013.

The Department has worked in collaboration with the State Department of Education, the Idaho Association of School Administrators, and several other school district representatives as part of a School-Based Medicaid Committee, to identify replacement services (both new and existing) that can be used to address children's developmental disabilities needs in the school setting. While developing these services, the committee kept in mind the purpose of Medicaid funding in the schools and regulations that must be followed under the State Plan authority.

Additional changes are being made to the pending rule based on the comments received from school providers during the public hearings and comment period. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 33 through 56**.

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

There is no anticipated fiscal impact to the state general fund. However, because of the change in covered school-based services benefits, schools that continue to deliver the old benefits may see a potential negative impact in federal funding of approximately $2.8 million.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 21st day of November, 2012.

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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Wednesday, September 19, 2012 6:00 p.m. (MDT Time)	**Wednesday, September 19, 2012 6:00 p.m. (PDT Time)**	**Wednesday, September 19, 2012 6:00 p.m. (MDT Time)**
1720 Westgate Dr. Suite A Boise, ID 83704	**2195 Ironwood Court Coeur d'Alene, ID 83814**	**421 Memorial Drive Pocatello, ID 83201**

If you are unable to attend a public hearing in any of the physical locations listed above, you can join the Boise public hearing from anywhere in the state via teleconference.

Teleconference number: 1-888-706-6468

Participant Code: 526505

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

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

In 2011, the Idaho Legislature approved the Children's System Redesign. Under the redesign, the Department is moving from a one-size-fits-all system that was only able to deliver therapy, to a system that provides a continuum of care based on the child's level of need. The new array of benefits replaces developmental therapy and intensive behavioral intervention (IBI) services.

Removing developmental disabilities benefits from the State Plan directly impacts the school-based service providers who deliver the same services. Rule changes are needed to incorporate replacement services for school-based providers when developmental therapy and IBI are no longer available starting July 1, 2013.

The Department has worked in collaboration with the State Department of Education, the Idaho Association of School Administrators, and several other school district representatives as part of a School-Based Medicaid Committee, to identify replacement services (both new and existing) that can be used to address children's developmental disabilities needs in the school setting. While developing these services, the committee kept in mind the purpose of Medicaid funding in the schools and regulations that must be followed under the State Plan authority.

The new replacement school-based services are proposed to be implemented on July 1, 2013.

Specifically, the following changes are being made:

1. References to DDA services are being removed from this chapter.
2. The services of developmental therapy and intensive behavioral intervention are being removed from the rules for school-based services.
3. Idaho Infant Toddler Program (ITP) is being removed from the rules for school-based services. The ITP delivers services in the home and community, rather than school setting. To better align with their service delivery system, the ITP will become a provider of community therapy services and community children's developmental disabilities services rather than be subject to school-based services requirements.
4. New behavioral intervention services are being added to the rules for school-based services.
5. Clarifications are being made to various existing school-based services and processes.

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

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

There is no anticipated fiscal impact to the state general fund. However, because of the change

in covered school-based services benefits, schools that continue to deliver the old benefits may see a potential negative impact in federal funding of approximately $2.8 million.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted on June 20, 2012. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 6, 2012, Idaho Administrative Bulletin, **Volume 12-6, pages 20 and 21**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Aaron Haws at (208) 364-1864.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1204

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

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

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

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

04. CDC Child and Teen BMI Calculator. The Centers for Disease Control (CDC)

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

05. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-30-07)

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

07. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at ~~*the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702*~~ http://www.infanttoddler.idaho.gov. ~~*(3-30-07)*~~( )

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

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

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

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

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

13. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State

St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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

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

02. Idaho Infant Toddler Program. The Idaho Infant Toddler Program serves children from birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. ( )

a. These requirements for the Idaho Infant Toddler Program include: ( )

i. Adherence to procedural safeguards and time lines; ( )

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

iii. Provision of early intervention services in the natural environment; ( )

iv. Transition planning; and ( )

v. Program enrollment and reporting requirements. ( )

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

i. Occupational therapy; ( )

ii. Physical therapy; ( )

iii. Speech-language pathology; ( )

iv. Audiology; and ( )

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

02~~2~~3. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

03~~3~~4. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

04~~4~~5. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

05~~5~~6. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

06~~6~~7. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

07~~7~~8. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

08~~8~~9. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

~~09~~10. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

~~10~~11. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)

~~1~~12. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

12~~2~~3. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

13~~3~~4. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The

resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)

14~~4~~5. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-30-07)

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

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

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

15~~5~~6. Medical Supplies. Items excluding drugs, biologicals, and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-30-07)

16~~7~~7. Midwife. An individual qualified as one of the following: (3-29-12)

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

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

17~~8~~8. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

18~~9~~9. Nonambulatory. Unable to walk without assistance. (3-30-07)

~~19~~20. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

20~~0~~1. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN)

who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ~~*(3-30-07)*~~( )

2~~1~~2. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

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

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

2~~4~~5. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

2~~5~~6. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

245. PROVIDERS OF SCHOOL-BASED SERVICES.
Only school districts~~,~~ and charter schools~~, *and the Idaho Infant Toddler Program*~~ can be reimbursed for the services described in Sections 850 through 856 of these rules. ~~*(3-30-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Enhanced Mental Health Services. Enhanced mental health services are not covered under the Basic Plan with the exception of assessment services. The assessment for determination of need for enhanced mental health services is subject to the requirements for

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

~~***02. Developmental Disability Agency Services (DDA).*** *DDA services are not covered under the Basic Plan with the exception of assessment and evaluation services. The assessment and/or evaluation for the need for DDA services is subject to the requirements for DDA services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 653.02, and IDAPA 16.04.11, "Developmental Disabilities Agencies," Sections 600 through 604.* (3-30-07)~~

0~~3~~2. Service Coordination Services. Service coordination services are not covered under the Basic Plan, with the exception of assessment services. The assessment for the need for service coordination services is subject to the requirements for service coordination under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 727.03, as applicable to the service being requested, and provider qualifications under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 729. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when provided by the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, ~~*developmental disability agencies,*~~ school-based services, Idaho Infant Toddler Program, independent practitioners, and home health agencies. ~~*(4-2-08)*~~( )

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT Manual) are covered with the following limitations: (4-2-08)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (4-2-08)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one, patient contact. (4-2-08)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. (4-2-08)

d. Any assessment provided under the heading "Orthotic Management and Prosthetic

Management" must be completed by the therapist. (4-2-08)

e. Any modality that is defined as "unlisted" in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. (4-2-08)

f. The services of therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. (4-2-08)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (4-2-08)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (4-2-08)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement. (4-2-08)

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a therapist or therapy assistant. (4-2-08)

d. Services provided by unlicensed aides or technicians, even if under the supervision of a therapist, except as provided under Section 854 of these rules. (4-2-08)

e. Massage, work hardening, and conditioning. (4-2-08)

f. Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

g. Maintenance programs, as defined under Section 730 of these rules. (4-2-08)

h. Duplicate services, as defined under Section 730 of these rules. (4-2-08)

i. Group therapy in settings other than school-based services and ~~*developmental disability agencies*~~ the Idaho Infant Toddler Program. ~~*(4-2-08)*~~( )

04. Service Limitations. (4-2-08)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may authorize additional therapy

services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

c. Exceptions to service limitations. (3-29-12)

i. Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. (3-29-12)

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. ~~(3-29-12)~~( )

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. (3-29-12)

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

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

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

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: (5-8-09)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (4-2-08)

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

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

a. General supervision of therapy assistants is required when therapy services are provided by outpatient hospitals, nursing facilities, home health agencies, outpatient rehabilitation

facilities, comprehensive outpatient rehabilitation facilities, the Idaho Infant Toddler Program, and providers of school-based services. ~~*(4-2-08)*~~( )

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

~~***c.*** *All therapy services provided in a developmental disabilities agency must be provided by the therapist in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."*~~ ~~*(4-2-08)*~~

(BREAK IN CONTINUITY OF SECTIONS)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

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

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

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

b. Therapists identified by Medicare as independent practitioners, licensed by the appropriate state licensing board and enrolled as Medicaid providers will be reimbursed on a fee-for-service basis. Exceptions to the requirement for Medicare certification include: (5-8-09)

i. Provider types that Medicare does not certify as is the case for speech-language pathologists; and (5-8-09)

ii. Providers that only treat pediatric participants and do not expect to treat Medicare participants. (5-8-09)

iii. Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid, the contact information for which is found in Section 005 of these rules. (5-8-09)

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

d. Payment for therapy services rendered to participants in long-term care facilities

~~*or Developmental Disabilities Agencies*~~ is included in the facility ~~*or agency*~~ reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~*(4-2-08)*~~( )

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

f. Payment for therapy services rendered by the Idaho Infant Toddler Program will be reimbursed on a fee-for-service basis. ( )

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-30-07)

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

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts~~,~~ and charter schools~~, and the Idaho Infant Toddler program~~ under the Individuals with Disabilities Education Act (IDEA). ~~*(3-30-07)*~~( )

04. Practitioner of the Healing Arts. A physician's assistant, nurse practitioner, or clinical nurse specialist who is licensed and approved by the state of Idaho to make such recommendations or referrals for Medicaid services. ( )

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts~~,~~ and charter schools~~, and the Idaho Infant Toddler Program~~ must ensure the student is: ~~*(3-30-07)*~~( )

01. Medicaid Eligible. Eligible for Medicaid and the service for which the school district~~,~~ or charter school~~, or Idaho Infant Toddler Program~~ is seeking reimbursement; ~~*(3-30-07)*~~( )

02. School Enrollment. Enrolled in an Idaho school district~~,~~ or charter school~~, or the Idaho Infant Toddler Program~~; ~~*(3-30-07)*~~( )

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

04. Educational Disability. ~~(3-30-07)~~

~~**a.**~~ Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness."~~; or~~ ~~(3-30-07)~~( )

~~***b.*** *A child from birth to three (3) years of age, who has been identified as needing early intervention services due to a developmental delay or disability or who meets the eligibility criteria of the Idaho Infant Toddler Program;~~ ~~(3-30-07)~~

05. Inpatients in Hospitals or Nursing Homes. Payment for school-related ~~*or Infant Toddler-based*~~ services will not be provided to students who are inpatients in nursing homes or hospitals. Health-related services for students residing in an ICF/ID are eligible for reimbursement. ~~(3-30-07)~~( )

06. Service-Specific Eligibility. Psychosocial Rehabilitation (PSR), ~~*Developmental Therapy, and Intensive*~~ Behavioral Intervention ~~*(IBI)*~~, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. ~~(3-30-07)~~( )

a. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 112, or the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/. Districts are to coordinate the delivery of services if the student is receiving PSR services authorized by the Department. ~~(3-30-07)~~( )

b. ~~*Developmental Therapy. To be eligible for developmental therapy, the student must meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501.*~~ Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must: ~~(3-30-07)~~( )

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

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

iii. Have maladaptive behaviors that interfere with the student's ability to access an

education. ( )

c. ~~*Intensive Behavioral Intervention (IBI). To be eligible for IBI services the student must:*~~ Personal Care Services. To be eligible for personal care services (PCS) the student must have a completed children's PCS assessment approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. ~~*(3-30-07)*~~( )

~~*i. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501; and (3-30-07)*~~

~~*ii. Display self-injurious, aggressive or severely maladaptive behavior evidenced by a score of minus twenty-two (-22) or below on the Scales of Independent Behavior-Revised (SIB-R), and demonstrate functional abilities that are fifty percent (50%) or less of his chronological age in at least one (1) of the following: verbal or nonverbal communication, social interaction, or leisure and play skills. (3-30-07)*~~

~~*iii. Be a child birth through the last day of the month of his twenty-first birthday who has self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, or leisure and play skills. (3-30-07)*~~

852. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts~~*,*~~ and charter schools~~*, and the Idaho Infant Toddler Program,*~~ for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. ~~*(3-30-07)*~~( )

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

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

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (3-30-07)

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

02. Evaluation And Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-30-07)

a. ~~*Recommended or Referred by a Physician or Other Practitioner of the Healing Arts.*~~ Be recommended or referred by a physician or other practitioner of the healing arts. ~~*licensed and approved by the state of Idaho to make such recommendations or referrals*~~ A school district or charter school may not seek reimbursement for services provided prior to receiving a signed

and dated recommendation or referral; ~~(3-30-07)~~( )

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

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

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

03. Reimbursable Services. School districts~~,~~ and charter schools~~, and the Idaho Infant Toddler program~~ can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts ~~licensed and approved by the state of Idaho to make such recommendations or referrals~~ for the Medicaid services for which the school district~~,~~ or charter school~~, or Idaho Infant Toddler Program~~ is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral. ~~(3-30-07)~~( )

a. ~~*Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability*~~. Behavioral Intervention. Behavioral Intervention is used to promote the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. The following staff-to-participant ratios apply: ~~(3-30-07)~~( )

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

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

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

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

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

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

i. Behavioral consultation cannot be provided as a direct intervention service. ( )

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

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

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

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

~~*e*~~**f.** Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements ~~*such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN)*~~. The provider must deliver at least one (1) of the following services: ~~*(3-30-07)*~~( )

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

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

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

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

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

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

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

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

hi. Psychotherapy. (3-30-07)

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

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

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

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

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

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

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

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is

being provided; (3-30-07)

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

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

n. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: ~~(3-30-07)~~( )

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

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

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

853. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of six (6) years: ( )

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services ~~C~~covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP) when the child turns three (3) years old, or Services Plan (SP)~~,~~ defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically-necessary health-related service~~s~~, and lists all the Medicaid reimbursable services for which the school district or charter school agency is requesting reimbursement~~; and~~. The IEP and transitional IFSP must include: ~~(3-30-07)~~( )

i. Type, frequency, and duration of the service(s) provided; ( )

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

iii. Measurable goals, when goals are required for the service; and ( )

iv. Specific place of service. ( )

02. ~~Referred by a Physician or Other Practitioner of the Healing Arts~~ Evaluations and Assessments. ~~Recommended or referred by 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, charter school, or the Idaho Infant Toddler Program is receiving reimbursement.*~~ Evaluations and assessments must support services billed to Medicaid, and must accurately reflect the student's current status. *Evaluations and assessments must be completed at least every (3) years.* ~~*(3-30-07)*~~( )

03. Service Detail Reports. A service detail report that includes: ( )

a. Name of student; ( )

b. Name and title of the person providing the service; ( )

c. Date, time, and duration of service; ( )

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

e. Category of service and brief description of the specific areas addressed; and ( )

f. Student's response to the service when required for the service. ( )

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

05. Documentation of Qualifications of Providers. ( )

06. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. ( )

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

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

07. Parental Notification. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 853.08 of this rule. ( )

08. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district or charter school billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. ( )

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and ( )

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

i. Results of evaluations within sixty (60) days of completion; ( )

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

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

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

854. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
~~*In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years*~~ Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: ~~*(3-30-07)*~~( )

01. ~~***Service Detail Reports***~~ **Behavioral Intervention**. ~~*A service detail report which includes:*~~ Behavioral intervention must be provided by or under the supervision of a professional. ~~*(3-30-07)*~~( )

a. ~~*Name of student;*~~ A behavioral intervention professional must meet the following: ~~*(3-30-07)*~~( )

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

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

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

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

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

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

b. ~~*Name and title of the person providing the service;*~~ A paraprofessional under the direction of a qualified behavioral intervention professional, must meet the following: ~~*(3-30-07)*~~( )

i. Must be at least eighteen (18) years of age; ( )

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

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

c. ~~*Date, time, and duration of service;*~~ A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the behavioral intervention service. ~~*(3-30-07)*~~( )

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

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

02. ~~***One Hundred Twenty Day Review***~~ **Behavioral Consultation**. ~~*A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan.*~~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: ~~*(3-30-07)*~~( )

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

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

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

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

e. An occupation therapist who is qualified and registered to practice in Idaho.( )

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

03. ~~Documentation of Qualifications of Providers~~ Medical Equipment and Supplies. See Subsection 852.03 of these rules. ~~(3-30-07)~~( )

04. ~~Copies of Required Referrals and Recommendations~~ Nursing Services. ~~Copies of required referrals and recommendations.~~ Nursing services must be provided by a registered nurse or licensed professional nurse (RN), or by a licensed practical nurse (LPN) licensed to practice in Idaho. ~~(3-30-07)~~( )

05. ~~Parental Notification~~ Occupational Therapy and Evaluation. ~~School districts, charter schools, and the Idaho Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule.~~ Occupation therapy and evaluation must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. ~~(3-30-07)~~( )

06. ~~Requirements for Cooperation with and Notification of Parents and Agencies~~ Personal Care Services. ~~Each school district, charter school, or Idaho Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student.~~ Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. ~~(3-30-07)~~( )

a. ~~Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts, charter schools, and the Idaho Infant Toddler program must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and~~ Providers of PCS must have at least one (1) of the following qualifications: ~~(3-29-12)~~( )

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

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

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

b. ~~*Notification to Primary Care Physician. School districts, charter schools, and the Idaho Infant Toddler program must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician:*~~ The registered nurse (RN) must complete the PCS assessment and develop the written plan of care annually. Oversight provided by the RN must include all of the following: ~~*(3-30-07)*~~( )

i. ~~*Results of evaluations within sixty (60) days of completion*~~ Development of the written PCS plan of care; ~~*(3-30-07)*~~( )

ii. ~~*A copy of the cover sheet and services page within thirty (30) days of the plan meeting*~~ Review of the treatment given by the personal assistant through a review of the student's PCS record as maintained by the provider; and ~~*(3-30-07)*~~( )

iii. ~~*A copy of progress notes, if requested by the physician, within sixty (60) days of completion*~~ Reevaluation of the plan of care as necessary, but at least annually. ~~*(3-30-07)*~~( )

c. ~~*Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district, charter school, or Idaho Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian.*~~ In addition to the RN oversight, the Qualified Intellectual Disabilities Professional (QIDP) as defined in 42 CFR 483.430 *provides oversight* for students with developmental disabilities *when identified as a need on the PCS assessment*. Oversight must include: ~~*(3-30-07)*~~( )

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

ii. Review of the developmental disabilities programs given by the personal assistant through a review of the student's PCS record as maintained by the provider and through on-site

observation of the student; and ( )

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

d. ~~*Parental Consent to Release Information. School districts, charter schools, and the Idaho Infant Toddler program:*~~ The RN, QIDP, or a combination of both, must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. ~~*(3-30-07)*~~( )

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

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

07. ~~***Provider Staff Qualifications***~~ **Physical Therapy and Evaluation**. ~~*Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services:*~~ Physical therapy and evaluation must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. ~~*(3-30-07)*~~( )

~~***a.*** *Developmental Therapy and Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Developmental Disabilities Agencies." Certified special education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (3-30-07)*~~

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

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

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

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

~~***f.*** *Physical Therapy and Evaluation. Must be provided by an individual qualified and*~~

~~licensed as a physical therapist to practice in Idaho.~~ ~~(3-30-07)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~ix. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners";~~ ~~(3-29-10)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~**l.** Social History and Evaluation. Must be provided by a licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (3-30-07)~~

~~**m.** Transportation. Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (3-30-07)~~

08. ~~***Paraprofessionals***~~ **Psychological Evaluation**. ~~*The schools and Infant Toddler Program may use paraprofessionals to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP.*~~ A psychological evaluation must be provided by a: ~~*(3-29-10)*~~( )

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

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

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

d. ~~*Developmental Therapy. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," for supervision and service requirements.*~~ Psychologist extender registered with the Bureau of Occupational Licenses; or ~~*(3-29-10)*~~( )

e. Certified school psychologist. ( )

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

a. Psychiatrist, M.D.; ( )

b. Physician, M.D.; ( )

c. Licensed psychologist; ( )

d. Licensed clinical social worker; ( )

e. Licensed clinical professional counselor; ( )

f. Licensed marriage and family therapist; ( )

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

h. Licensed professional counselor whose provision of psychotherapy is supervised

in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ( )

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

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

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

10. Psychosocial Rehabilitation (PSR). Psychosocial rehabilitation must be provided by a: ( )

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

b. Licensed master's level psychiatric nurse; ( )

c. Licensed psychologist; ( )

d. Licensed clinical professional counselor or professional counselor; ( )

e. Licensed marriage and family therapist or associate marriage and family therapist; ( )

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; ( )

g. Psychologist extender registered with the Bureau of Occupational Licenses;( )

h. Licensed professional or registered nurse (RN); ( )

i. Psychosocial rehabilitation specialist as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131; ( )

j. Licensed occupational therapist; ( )

k. Certified school psychologist; or ( )

l. Certified school social worker. ( )

11. Speech/Audiological Therapy and Evaluation. Speech/audiological therapy and evaluation must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing

Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. ( )

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

13. Transportation. Transportation must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. ( )

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

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

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

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

855. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.

Payment for health-related services provided by school districts~~,~~ and charter schools~~, *and the Idaho Infant Toddler program*~~ must be in accordance with rates established by the Department. ~~*(3-30-07)*~~( )

01. Payment in Full. Providers of services must accept as payment in full the school district~~,~~ or charter school~~, *or Idaho Infant Toddler Program*~~ payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. ~~*(3-30-07)*~~( )

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

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

04. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-30-07)

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

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

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

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

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

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

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

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

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1205

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2013**. The pending rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code.

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

These temporary rules implement a patient-centered medical home model of care that will coexist with the primary care case management structure called Healthy Connections. In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. The pending rule is being amended for clarity. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 300 through 313**.

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

To provide better coordination of benefits and services for Medicaid participants by implementation of the Governor's medical home initiative, known as Health Homes.

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

No fiscal impact to the state general fund is expected as anticipated savings from better coordination of care and reduction in service utilization will offset any additional costs.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Cindy Brock at (208) 364-1983.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Tuesday - October 23, 2012 - 2:00 p.m. MDT

Medicaid Central Office
Conference Room D-East and D-West
3232 Elder Street
Boise, ID 83705

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

The rule amendments in this docket are being made to address the Governor's medical home initiative that has been developed over the past two years to provide better coordination of care for eligible individuals with chronic diseases and for covered services needed. The Idaho Medicaid Health Home is Medicaid's response to a multi-payer collaborative initiative in an effort to reduce ER visits, hospital admits, and prevention of co-morbid conditions. These rules implement a patient-centered medical home model of care that will coexist with the primary care case management structure called Healthy Connections.

These changes provide for the administration of the Idaho Medicaid Health Home program, which includes Home Health Services, definitions, participant eligibility including coverage and

limitations, provider qualifications, procedural requirements, reimbursement structure, and quality assurance. In addition, the Healthy Connections program structure and rules have be revised and updated to describe the relationship between the Health Home program and the Healthy Connections program.

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

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

No fiscal impact to the state general fund is expected as anticipated savings from better coordination of care and reduction in service utilization will offset any additional costs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not initiated or feasible since the changes in this rulemaking are based on a collaborative group of stakeholders set up by the Governor for the medical home initiative. There has been extensive participation in these meetings and input has been provided on the Idaho Medicaid Health Home program.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

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 October 24, 2012.

DATED this 31st day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1205

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

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

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

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 5~~6~~7**9** of these rules**.** (5-8-09)

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

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

06. Prevention Services. The range of prevention services covered is described in Sections 5~~7~~8**0** through 649 of these rules. ~~(5-8-09)~~( )

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

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

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

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

~~*e*~~**d.** Diagnostic Screening Clinic services are described in Sections 610 through 61~~6~~4. ~~*(3-30-07)*~~( )

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

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

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

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

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

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

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

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

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

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

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

b. Mental Health Clinic services are described in Sections 707 through 71~~8~~9. ~~*(3-30-07)*~~( )

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

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

14. Audiology Services. Audiology services are described in Sections 740 through

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

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

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

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

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

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

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery of Outpatient Services. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. ~~(3-30-07)~~( )

02. Follow-Up for Emergency Room Patients with Chronic Conditions. Hospitals must establish procedures to refer Medicaid participants with targeted chronic diseases defined in Section 560 of these rules to an Idaho Medicaid Health Home provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Health Home provider with that PCP. ( )

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560 -- 5~~6~~79)

560. HEALTHY CONNECTIONS AND IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of this Sub Area that includes Sections 560 through 579 of these rules, ~~*unless the context clearly requires otherwise,*~~ the following ~~*words and*~~ terms ~~*have the following meanings*~~ and definitions apply: ~~(3-30-07)~~( )

01. Best Practices Protocol. A regimen of proven, effective and evidence-based practices. (4-2-08)

02. Care Plan. A patient specific document that identifies health care orders for the patient and serves as a guide to care. It can either be written for an individual patient or be retrieved from a computer and individualized. ( )

0~~2~~3. Chronic Disease Management. The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. (4-2-08)

0~~3~~4. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)

0~~4~~5. Covered Services. Those medical services and supplies for which reimbursement

is available under the State Plan. (3-30-07)

0~~5~~6. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)

07. Health Home. A primary care provider organization contracted with Medicaid to lead a team approach for chronic disease management. The Health Home provides comprehensive patient centered care management and health promotion services to patients with chronic conditions in accordance with the requirements described in section 560 through 579 of these rules and Section 1945 of the Social Security Act. ( )

08. Health Information Technology. Electronic tools utilized to securely exchange or manage health information between two or more entities. ( )

0~~6~~9. Healthy Connections. The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as managed care. Healthy Connections is a primary care case management model. (4-2-08)

10. Individual or Family Supports. Community based social supports or recovery services available to assist individuals or families in need. ( )

11. National Committee for Quality Assurance (NCQA). Accrediting organization which develops health care performance measurements and provides certifications of quality to health care providers. ( )

~~***07. Pay for Performance**. The use of incentives to encourage and reinforce the delivery of evidence-based practices that promote better outcomes as efficiently as possible.*~~
~~*(4-2-08)*~~

12. Preventive Care. Medical care that focuses on disease prevention and health maintenance. ( )

~~0~~8~~8~~13. Primary Care Case Management. The process in which a primary care provider is responsible for direct care of a participant, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the participant. (4-2-08)

~~0~~9~~9~~14. Primary Care Provider (PCP). A qualified medical professional who contracts with Medicaid to coordinate the care of certain participants enrolled in the Healthy Connections program. ~~*(4-2-08)*~~( )

1~~0~~5. Qualified Medical Professional. A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (3-30-07)

16. Quality Improvement Program. A program of organized, ongoing, and

systematic efforts to improve and assess the quality of care within a primary care provider practice or organization. ( )

17. **Quality Measures**. A measure of health care performance based on specified dimensions of care and service. ( )

~~1~~18. Referral. ~~*The process by which*~~ A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing ~~*participants gain access to those*~~ specific covered services subject to primary care case management~~, *but* that~~ are not provided by the ~~*primary care provider*~~ participant's PCP. ~~*It is the authorization for such services.*~~ ~~*(3-30-07)*~~( )

19. **Risk Factor.** A characteristic, condition, or behavior that increases the possibility of disease or injury. ( )

~~1~~20. Targeted Chronic Disease. ~~*One (1) of the diseases included in the chronic disease management pay-for-performance program. The specific targeted chronic diseases are diabetes, asthma, hypertension, hyperlipidemia, and depression. The Department may change the diseases included in the program after appropriate notification to PCPs.*~~ A disease identified by the Department for management under the Idaho Medicaid Health Home program. Specific conditions are identified in the Medicaid Provider Handbook available at www.idmedicaid.com. ~~*(4-2-08)*~~( )

21. **Transitional Care**. The care or services provided by a health care provider to ensure care of the patient as they move between health care settings or between healthcare providers. ( )

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

~~***01. Voluntary County***~~. ~~*In a county where participation in Healthy Connections is voluntary, the participant will be given an opportunity to choose a PCP. If the participant is unable to choose a provider but wishes to participate, a provider will be assigned by the Department. If a voluntary county subsequently becomes a mandatory county, provider selection and assignment will remain unchanged where possible.*~~ ~~*(4-2-08)*~~

0~~2~~1. ~~***Mandatory County***~~. ~~*In a county where participation*~~ **Primary Care Case Management Enrollment**. Each participant in Idaho Medicaid is enrolled in Healthy Connections~~ *is mandatory*~~, unless the participant is granted an exemption by the Department described in Subsections 561.02.a. through 561.02.h. of this rule. Each participant must choose a PCP within the Healthy Connections program. If a participant fails to choose a PCP, one will be assigned ~~*if the participant fails to choose a participating provider after given the opportunity to do so*~~ to the participant by the Department. ~~*Members*~~ Participants of the same family ~~*do not have to*~~ may choose ~~*the same*~~ different Healthy Connections providers. ~~*All participants in the county are required to participate unless individually granted an exception.*~~ ( )

02. ~~***Exceptions***~~ **Exemption from Participation**. An exemption from participation in ~~*a mandatory county are available*~~ Healthy Connections may be granted on a individual basis by the Department for a participant~~s~~ who: ~~*(4-2-08)*~~( )

a. ~~Have to travel more than~~ Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; ~~(3-30-07)~~( )

b. Ha~~ve~~s an eligibility period that is less than three (3) months; ~~(3-30-07)~~( )

c. Ha~~ve~~s an eligibility period that is only retroactive; ~~(3-30-07)~~( )

d. ~~Are~~ Is eligible only as a Qualified Medicare Beneficiary; ~~(3-30-07)~~( )

e. Ha~~ve~~s an existing relationship with a primary care physician or clinic who is not participating ~~with the~~ in Healthy Connections; ~~or~~ ~~(3-30-07)~~( )

~~**f.** Has incompatible third party liability.~~ ~~(3-30-07)~~

~~**g**~~**f.** ~~Are~~ Is enrolled in the Medicare/Medicaid Coordinated Plan.; ~~(4-2-08)~~( )

g. Resides in a nursing facility or an ICF/ID; or ( )

h. Resides in a county where there are not an adequate number of providers to deliver primary care case management services. ( )

562. HEALTHY CONNECTIONS: COVERAGE AND LIMITATIONS.

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

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

b. Treatment for ~~E~~emergency ~~care (as defined by the Department for the purpose of payment and performed in an emergency department)~~ medical conditions defined in Subsection 010.23 of these rules; and ~~(3-30-07)~~( )

c. Hospital admissions subsequent to an emergency room visit provided that the patient's discharge is coordinated with a PCP; ( )

~~**c**~~**d.** Dental care; (4-2-08)

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

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

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

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

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

~~**i**~~**j.** Nursing home; (3-30-07)

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

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

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

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

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

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

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

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

~~r~~s. Anesthesiology services; (3-29-12)

~~s~~t. Radiology services; ~~and~~ ~~(3-29-12)~~( )

~~t~~u. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed~~.~~; ~~(3-29-12)~~( )

v. School-based services; ( )

w. Services managed directly by the Department, as defined in the provider handbook for those services at www.idmedicaid.com; and ( )

x. Pregnancy related services provided by an obstetrician or gynecologist not enrolled as a Healthy Connections provider. ( )

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

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Primary Care Case Management. Under the Healthy Connections model of managed care, each participant obtains medical services through a PCP. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services. (4-2-08)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require receipt of a referral prior to delivery of services. Services that require a referral, but are provided without a referral ~~will~~ are not ~~be paid~~ covered. All referrals must be

documented in the participant's patient record. ~~(3-30-07)~~( )

b. Changing PCP~~s~~. If a participant is dissatisfied with his PCP, he may change providers ~~effective the first day of any month~~ by contacting his designated Healthy Connections Representative ~~to do so no later than fifteen~~ at least ten (1~~5~~0) days ~~in advance~~ prior to the end of the month. The change is effective the first day of the following month. This advance notice requirement may be waived by the Department. ~~(4-2-08)~~( )

c. Changing Service Areas. A ~~P~~participant~~s~~ who move~~s~~ from the area where ~~they are~~ he is enrolled must ~~disenroll in the same manner as provided in the preceding paragraph for changing PCPs, and may obtain a referral from their PCP pending the transfer. Such referrals are valid not to exceed thirty (30) days~~ contact his designated Healthy Connections Representative to disenroll from his current PCP and enroll with a new PCP in the area where moving. Enrollment with the new PCP is effective the first day of the month following the request. ~~(4-2-08)~~( )

02. Problem Resolution. (3-30-07)

a. ~~Intent.~~ To help assure the success of Healthy Connections, the Department ~~intends to~~ provide~~s~~ a mechanism for timely and personal attention to problems and complaints related to the program . ~~(3-30-07)~~( )

b. ~~Local Program Representative.~~ To facilitate problem resolution, ~~each area~~ the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. ~~(4-2-08)~~( )

c. ~~Registering a Complaint. Both~~ A participant~~s and~~ or a provider~~s~~ may register a complaint or notify the Department of a problem related to Healthy Connections either ~~by~~ in writing, electronically, or by telephon~~ing~~e to the ~~local program~~ designated representative. The ~~health~~ designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. ~~(3-30-07)~~( )

d. ~~Grievance.~~ If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the ~~program~~ designated representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. ~~(3-30-07)~~( )

e. ~~Appeal.~~ Decisions in response to grievances may be appealed. Appeals ~~by participants~~ are ~~considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings,~~ governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed ~~in accordance with~~ according to the provisions of that chapter. ~~(3-30-07)~~( )

~~**03. Chronic Disease Management Registration**. A participating PCP must initially register each participant eligible for chronic disease management reimbursement with the~~

~~*Department.*~~ ~~*(4-2-08)*~~

~~***04. Chronic Disease Management Reporting.*** *A participating PCP must annually report on all identified quality indicators for each targeted chronic disease that he seeks reimbursement as specified in the provider agreement. The reporting schedule is established by the Department in the provider agreement.*~~ ~~*(4-2-08)*~~

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Participation Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (3-30-07)

02. Provider Participation Conditions and Restrictions. (3-30-07)

a. Quality of Services. Each ~~P~~provider must: ( )

i. ~~m~~Maintain and provide services in accordance with community standards of care~~. *Provider must*~~; ( )

ii. ~~e~~Exercise his best efforts to effectively control utilization of services~~. *Providers must*~~; and ( )

iii. ~~p~~Provide twenty-four (24) hour coverage by telephone to assure participant access to services. ~~*(3-30-07)*~~( )

b. Provider Agreements. Each *independent* ~~P~~provider~~s~~ *or provider organization* participating in primary care case management must: ( )

i. ~~s~~Sign an agreement~~. *Clinics may sign an agreement on behalf of their qualified medical professionals.*~~; ( )

ii. Enroll with the Department all primary care *providers and all* clinic locations *participating in the* Healthy Connections *program*; and ( )

iii. ~~*Providers participating in the chronic disease management pay-for-performance program must*~~ ~~s~~Sign an addendum to the primary care case management provider agreement when participating in the Idaho Medicaid Health Home program. ~~*(4-2-08)*~~( )

c. Patient Limits. A ~~P~~provider~~s~~ may limit the number of participants ~~*they wish to*~~ *he* manages. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A ~~P~~provider~~s~~ may change the~~*ir*~~ participant limit effective the first day of any month~~. *by written request*~~ The *provider* must make the request in writing to the Department thirty (30) days prior to the effective date of the change. This advance notice ~~R~~requirement maybe waived by the Department. ~~*(3-30-07)*~~( )

d. Disenrollment. ~~*Instances may arise where*~~ When the provider-patient relationship breaks down due to failure of the participant to follow the ~~*plan of*~~ care plan or for other reasons~~. *Accordingly*~~, a provider may choose to withdraw as the participant's primary care provider

effective the first day of any month. ~~by written notice to~~ The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. ~~(3-30-07)~~( )

e. Record Retention. Each ~~P~~providers must: ( )

i. ~~r~~Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service~~.~~; ( )

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP~~. Provider must also~~; and ( )

iii. ~~d~~Disclose information required by Subsection 205.01 of these rules, when applicable. ~~(4-2-08)~~( )

f. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

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

a. A PCP~~s will be~~ is paid a case management fee for primary care case management services based on the level of each participant's health care needs ~~and the PCP's availability~~. ~~(3-29-12)~~( )

b. A PCP~~s~~ enrolled in the ~~chronic disease management pay-for-performance~~ Idaho Medicaid Health Home program ~~will be~~ is paid a~~n enhanced~~ chronic disease case management fee. ~~(4-2-08)~~( )

c. The amount of the fee~~s~~ is determined by the Department. ~~(3-29-12)~~( )

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

02. Primary Care Case Management. Reimbursement is based on: (3-29-12)

a. The number of participants enrolled ~~under~~ with the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package; ~~(3-29-12)~~( )

b. The number of participants enrolled ~~under~~ with the provider on the first day of each month, multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and ~~(3-29-12)~~( )

c. ~~The amount of the case management fee is increased by fifty cents ($.50) per participant~~ An incentive payment is added per participant to the primary care case management fee in Subsection 565.01.a. of this rule when the PCP~~'s office~~ offers extended hours of service in one (1) of the following ways: ( )

i. The number of hours the PCP's office is available for delivery of service to participants equals ~~to~~ or exceed~~ing~~s forty-six (46) hours per week. The ~~amount of~~ extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee ~~generation for the increase to be paid.~~; or ~~(3-29-12)~~( )

ii. The PCP has electronic health records available and accessible for delivery of services at a nearby service location that is within the same Healthy Connections provider organization and makes services available to the participant at least forty-six (46) hours per week. The alternate location and extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee. ( )

d. The number of participants enrolled with an Idaho Medicaid Health Home provider on the first day of the month for services described in Section 572 these rules, multiplied by the case management fee established per participant enrolled in that program. ( )

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

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

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

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of ~~Chronic Disease Management~~ the primary care case management programs. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ~~(4-2-08)~~( )

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES

(Sections 570 -- 649)

[SECTION 570 MOVED TO SECTION 618]

570. IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of the Idaho Medicaid Health Home program, the terms and definitions in Section 560 of these rules apply. ( )

571. IDAHO MEDICAID HEALTH HOME: PARTICIPANT ELIGIBILITY.

01. Eligibility. A Medicaid participant diagnosed with two (2) targeted chronic

diseases, or one (1) targeted chronic disease and one (1) or more risk factors is eligible for enrollment in the Idaho Medicaid Health Home program. ( )

02. Eligibility Determination. A participant who meets the diagnostic criteria for health home eligibility is identified by the PCP to the Department. The Department will utilize claims data and other documentation as needed to verify the participant is eligible for Idaho Medicaid Health Home services. ( )

572. IDAHO MEDICAID HEALTH HOME: COVERAGE AND LIMITATIONS.
The following services are covered for an eligible participant assigned to a Health Home provider: ( )

01. Comprehensive Care Management. A Health Home provider must develop and implement a patient-centered care plan based on an individual's health risk assessment. The care plan must describe how the Health Home provider will coordinate clinical care with other providers as well as non-clinical health care related needs and services. ( )

02. Care Coordination and Health Promotion. A Health Home provider must: ( )

a. Coordinate the participant's care by sharing clinical information relevant to patient care with other providers; ( )

b. Provide educational information and information about health care resources to the participant; ( )

c. Have ongoing communication with the participant to encourage compliance with prescribed treatment; and ( )

d. *Provide* other activities necessary to facilitate improved health outcomes for the participant. ( )

03. Comprehensive Transitional Care. A Health Home provider must: ( )

a. Receive relevant medical information from and share relevant medical information with *emergency rooms and* inpatient facilities to foster a coordinated approach to preventing avoidable readmissions; and ( )

b. Review and update care plans after unplanned admissions to adjust care coordination and management activities to address identifiable causes for the admission. ( )

04. Individual, Family, Community, and Social Support Services. A Health Home provider must: ( )

a. Coordinate care in a manner that effectively utilizes available individual and family supports to improve and maintain the health of the participant; and ( )

b. Provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors. ( )

573. IDAHO MEDICAID HEALTH HOME: PROCEDURAL REQUIREMENTS.

01. Provider Agreement. A Health Home provider must sign an addendum to the primary care case management provider agreement which identifies the location of the Health Home and other requirements necessary to meet the Health Home service requirements in these rules. ( )

02. Data Reporting. Health Home providers must report data to the Department on a periodic basis in keeping with schedules outlined in the provider handbook and the terms of the Health Homes provider agreement. ( )

03. Quality Improvement Program. A provider must establish a continuous quality improvement program directed towards improving care for patients with chronic conditions. ( )

574. IDAHO MEDICAID HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Infrastructure and Health Home Assessment. A prospective Health Home provider must complete a Health Home practice assessment in cooperation with the Department to determine the ability of the provider to provide the required services in keeping with a patient-centered medical home model. This assessment must demonstrate that the provider; ( )

a. Has identified the qualified medical *and mental health* professionals and other resources available to provide Health Home services; ( )

b. Has the ability to utilize health information technology to coordinate and facilitate communication of health information and to link to services; ( )

c. Is able to submit clinical and practice transformation data within six (6) months of the date the provider agreement is signed; and ( )

d. Has a chronic disease patient registry in place within three (3) months of the date the provider agreement is signed. ( )

02. Qualifications. An Idaho Medicaid Health Home provider must: ( )

a. Possess a current NCQA patient-centered medical home level one (1) *recognition*, or demonstrate that the provider is actively pursuing that recognition. A provider that does not achieve this NCQA *recognition* within two (2) years of the initiation date of their Idaho Medicaid Health Home provider agreement will be terminated as a Health Home provider for non-compliance with the provider agreement; ( )

b. Be enrolled as a Healthy Connections primary care provider (PCP); ( )

c. Sign an addendum to their primary care provider agreement which identifies the location of the enrolled site and indicates reporting schedule and quality measurement requirements; . ( )

d. Have qualified medical professionals, licensed to practice in the state where services are being rendered; and ( )

e. Maintain office hours that allow enhanced access to care as described in Section 565.02 of these rules. ( )

03. Provider Duties. A Health Home provider must provide or coordinate the following elements of Health Home services: ( )

a. Care Plan. Develop a patient-centered care plan for each participant that coordinates and integrates both clinical and non-clinical health care related needs and services; ( )

b. Chronic Disease Management. Provide access to chronic disease management, including self- management support to the participant and the participant's family; ( )

c. Individual, Family, and Community Supports. Facilitate access to individual, family, and community supports outlined in the provider's agreement. ( )

d. Mental Health & Substance Abuse Services. Facilitate access to mental health and substance abuse services. ( )

e. Preventive Care. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance abuse disorders. ( )

f. Quality Improvement Program. Establish a continuous quality improvement program and report on quality improvement measures outlined in the provider agreement *and the provider handbook*. ( )

g. Quality of Services. Maintain and provide quality services for each Home Health participant. ( )

h. Transitional Care. Coordinate and provide access to comprehensive care management and transitional care from and to inpatient settings and from a pediatric to an adult system of health care. ( )

575. (RESERVED)

576. IDAHO MEDICAID HEALTH HOME: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the Idaho Medicaid Health Home program through the collection and reporting of quality measures as specified in Section 1945 of the Social Security Act. ( )

57~~1~~7. -- 579. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 5~~7~~80 -- 649)

(BREAK IN CONTINUITY OF SECTIONS)

616. -- 61~~9~~7. (RESERVED)

~~570~~618.HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described in Section 620 of these rules. (3-30-07)

619. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1206

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code, Section 1905(r) of the Social Security Act, and 42 CFR Section 441.56.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule regarding Idaho's Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 314 and 315**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cindy Brock at (208) 364-1983.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code, Section 1905(r) of the Social Security Act, and 42 CFR Section 441.56.

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

Monday - October 22, 2012 - 2:00 p.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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

The Centers for Medicare and Medicaid Services (CMS) provided guidance regarding the federal requirements for EPSDT coverage based on its review of Idaho's Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program. This rule change reflects direction from CMS and adds a definition of medically necessary services for EPSDT.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted nor feasible because the changes are being made to align the state's rules with federal regulations.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1206

880. ~~*(RESERVED)*~~ EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES: DEFINITION.

Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of medical practice. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The text of the pending rule regarding the process for providing cost information to the Department has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 316 through 320**.

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

The changes in this rulemaking are meant to be budget neutral and have no fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 19th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Wednesday - October 24, 2012
1:00 p.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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 2012 Legislature requested the Department work with providers to determine an effective process for reporting and providing information in an effective manner for evaluation of provider rates of reimbursement set by Medicaid that is not already based on another established rate methodology. These proposed rules provide a process for providers to report costs incurred and for the Department to determine rates based on those reports.

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

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

The changes in this rulemaking are meant to be budget neutral and have no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012, Idaho Administrative Bulletin, **Vol. 12-5, page 71**.

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

these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sheila Pugatch at (208) 364-1817.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1201

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. 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. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

a. The provider's actual charge for service; or (3-19-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-19-07)

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (3-19-07)

~~***03. Payment for Therapy Services**. The fees for physical therapy, occupational therapy, and speech-language pathology services include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment.* (4-2-08)~~

~~***037. -- 038. (RESERVED)***~~

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.
The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. ( )

01. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in Subsections 037.02 and 037.03 of this rule. ( )

02. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. ( )

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or ( )

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. ( )

03. Quality. The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue. ( )

04. Cost Survey. The Department will survey one hundred percent (100%) of providers. Providers that refuse or fail to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. The Department will conduct cost surveys customized for each of the services defined in Section 038 of these rules. ( )

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. ( )

b. For employer related expenditures: ( )

i. The Bureau of Labor Statistics's report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. ( )

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. ( )

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. ( )

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

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

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

03. Personal Care Services. The fees for personal Care Services (PCS) described in Section 300 of these rules. ( )

04. Aged and Disabled Waiver Services. The fees for personal care services (PCS) described in Section 320 of these rules. ( )

05. Children's Waiver Services. The fees for children's waiver services described in Section 680 of these rules. ( )

06. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. ( )

07. Service Coordination. The fees for service coordination described in Section 720 of these rules. ( )

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

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department ~~*on an annual basis*~~. Provider

claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ~~(3-21-12)~~( )

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the ~~RMS~~ Department or its contractor under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.0~~7~~8 of ~~these~~ this rule~~s~~. ~~(3-19-07)~~( )

03. Weighted Average Hourly Rate~~s~~ Methodology. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. ~~(3-29-10)~~( )

04. Payment for Personal Assistance Agency. Payment for personal assistance agency services will be paid according to rates established by the Department. ~~(3-4-11)~~( )

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR. ~~For State Fiscal Year 2012, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2011.~~

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

~~(3-21-12)~~( )

b. ~~Beginning with State Fiscal Year 2013, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted,~~ t~~T~~he Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. ~~(3-21-12)~~( )

c. ~~Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component.~~ The Department will survey one hundred percent (100%) of personal care service providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider.

~~(3-4-11)~~( )

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the ~~*RMS*~~ Department or its contractor.
~~*(3-19-07)*~~( )

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the ~~*RMS*~~ Department or its contractor.
~~*(3-19-07)*~~( )

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. ~~*Beginning with State Fiscal Year 2013, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training.*~~ Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior

State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

~~(3-21-12)~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is **October 1, 2012**. This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Medicaid's Adult Developmental Disabilities and Aged and Disabled Home and Community Based Services (HCBS) waivers (also known as 1915(c) waivers) were scheduled to expire on September 30, 2012. In order for Idaho to maintain waiver authority and offer waiver benefits, a new waiver application for each was submitted to, and approved by, the Centers for Medicare and Medicaid Services (CMS). As a result, these rule changes are needed to realign this chapter of rules with the waivers that were renewed and are effective October 1, 2012.

Revisions are being made at the pending stage of the rule process in order to:

1. Make improvements to rules based on written and verbal stakeholder comments; and

2. Better align language regarding provider record requirements for Aged and Disabled waiver providers under IDAPA 16.03.10.328.06 with the Personal Care Services (PCS) record requirements under Subsections 304.04.e. and 304.04.f.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 321 through 355**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mark Wasserman at (208) 287-1156.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **October 1, 2012**.

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

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

Thursday - October 18, 2012 - 5 p.m. MDT

DHW Region IV Office
1720 N. Westgate Drive
Suite A, Room 131
Boise, ID 83704

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Medicaid's Adult Developmental Disabilities and Aged and Disabled Home and Community Based Services (HCBS) waivers (also known as 1915(c) waivers) expire on September 30, 2012. In order for Idaho to maintain waiver authority and offer waiver benefits, a new waiver application for each must be submitted to the Centers for Medicare and Medicaid Services (CMS)

and be approved. As a result, these rule changes are needed to realign this chapter of rules with the waivers that are being updated and are effective October 1, 2012.

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

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

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

This rulemaking has no anticipated fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted on May 31, 2012. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012, Idaho Administrative Bulletin, **Volume 12-5, page 72**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Mark Wasserman at (208) 287-1156.

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 October 24, 2012.

DATED this 10th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1202

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

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

02. Additional Criminal Convictions. Once an individual has received a criminal

history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

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

a. Adult Day ~~*Care*~~ Health Providers. The criminal history and background check requirements applicable to providers of adult day ~~*care*~~ health as provided in Sections 329 and 705 of these rules. ~~*(4-2-08)*~~( )

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

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

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section~~*s 329 and*~~ 705 of these rules. ~~*(4-2-08)*~~( )

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

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

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

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

i. Day ~~*Reh*~~Habilitation Providers. The criminal history and background check requirements applicable to day ~~*re*~~habilitation providers as provided in Section 329 of these rules. ~~*(4-2-08)*~~( )

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

k. Homemaker Services Providers. The criminal history and background check

requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)

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

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

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

~~*o. Psychiatric Consultation Providers. The criminal history and background check requirements applicable to psychiatric consultation providers as provided in Section 329 of these rules. (4-2-08)*~~

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

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

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

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

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

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

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

010. DEFINITIONS: A THROUGH D.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or ~~*instrumental*~~ activities of daily living (~~I~~ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. ~~(5-8-09)~~( )

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider’s financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider’s records. (3-19-07)

11. Audit Reports. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)

12. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)

13. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)

15. Case Mix Adjustment Factor. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of

each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. Certified Family Home. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. Chain Organization. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)

19. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. Clinical Nurse Specialist. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

21. Common Ownership. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

22. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)

23. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

24. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)

25. Cost Component. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

26. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)

27. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

28. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

29. Costs Related to Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)

30. Costs Not Related to Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

31. Customary Charges. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

32. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

33. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

34. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

35. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

36. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

37. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

38. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

321. AGED OR DISABLED WAIVER SERVICES: DEFINITIONS.
The following definitions apply to Sections 320 through 330 of these rules: (3-19-07)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (3-19-07)

02. Individual Service Plan. A document ~~*which*~~ that outlines all services including~~,~~

~~but not limited to, personal assistance services~~ activities of daily living (ADL) and instrumental activities of daily living (IADL), required to maintain the individual in his home and community. The plan is initially developed by the ~~RMS~~ Department or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the ~~RMS~~ Department or its contractor, and all Medicaid reimbursable services must be contained in the plan. ~~(3-19-07)~~( )

03. Personal Assistance Agency or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (3-19-07)

04. Employer of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary agency. (5-8-09)

05. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (3-19-07)

06. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (3-19-07)

322. AGED OR DISABLED WAIVER SERVICES: ELIGIBILITY.
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: (3-19-07)

01. Has a Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (3-19-07)

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (3-19-07)

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility. (4-2-08)

04. Functional Level for Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its contractor. In determining need for nursing facility care an adult must require the level of assistance listed in Subsections 322.04 through 322.07 of this rule, according to the formula described in Subsection 322.08 of this rule. ~~(4-2-08)~~( )

05. Critical Indicator - 12 Points Each. (4-2-08)

a. Total assistance with preparing or eating meals. (4-2-08)

b. Total or extensive assistance in toileting. (4-2-08)

c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (4-2-08)

06. High Indicator - 6 Points Each. (4-2-08)

a. Extensive assistance with preparing or eating meals. (4-2-08)

b. Total or extensive assistance with routine medications. (4-2-08)

c. Total, extensive or moderate assistance with transferring. (4-2-08)

d. Total or extensive assistance with mobility. (4-2-08)

e. Total or extensive assistance with personal hygiene. (4-2-08)

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (4-2-08)

07. Medium Indicator - 3 Points Each. (4-2-08)

a. Moderate assistance with personal hygiene. (4-2-08)

b. Moderate assistance with preparing or eating meals. (4-2-08)

c. Moderate assistance with mobility. (4-2-08)

d. Moderate assistance with medications. (4-2-08)

e. Moderate assistance with toileting. (4-2-08)

f. Total, extensive, or moderate assistance with dressing. (4-2-08)

g. Total, extensive or moderate assistance with bathing. (4-2-08)

h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (4-2-08)

08. Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (4-2-08)

a. One (1) or more critical indicators = Twelve (12) points. (4-2-08)

b. Two (2) or more high indicators = Twelve (12) points. (4-2-08)

c. One (1) high and two (2) medium indicators = Twelve (12) points. (4-2-08)

d. Four (4) or more medium indicators = Twelve (12) points. (4-2-08)

323. AGED OR DISABLED WAIVER SERVICES: PARTICIPANT ELIGIBILITY DETERMINATION.
Waiver eligibility will be determined by the ~~*RMS*~~ Department or its contractor. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." In addition, waiver participants must meet the following requirements. ~~*(3-19-07)*~~( )

01. Requirements for Determining Participant Eligibility. The ~~*RMS*~~ Department or its contractor must determine that: ~~*(3-19-07)*~~( )

a. The participant would qualify for nursing facility level of care under Sections 222 and 223 of these rules**,** if the waiver services listed in Section 326 of these rules were not made available; and (3-19-07)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must be made by the ~~*RMS*~~ Department or its contractor. Prior to any denial of services on this basis, the Department or its contractor must verify that services to correct the concerns of the team are not available. ~~*(3-19-07)*~~( )

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 nursing facility care.(3-19-07)

d. Following the approval by the ~~*RMS*~~ Department or its contractor 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. ~~*(3-19-07)*~~( )

02. Admission to a Nursing Facility. A participant who is determined by the ~~*RMS*~~ Department or its contractor to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility. ~~*(3-19-07)*~~( )

03. Redetermination Process. Case Redetermination will be conducted by the ~~*RMS*~~ Department or its contractor. The redetermination process will verify that the participant continues to meet nursing facility level of care and the participant's continued need for waiver services. ~~*(3-19-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day ~~Care~~ Health. ~~*Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living.*~~ Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ~~*(3-19-07)*~~( )

02. Adult Residential Care Services. Adult residential care ~~S~~services ~~*are those that*~~ consist of a range of services provided in a ~~*congregate*~~ homelike, non-institutional setting that include residential care or assisted living facilities and certified family homes. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. ( )

a. Adult residential care services consist of a range of services provided in a congregate setting licensed ~~*in accordance with*~~ under IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that include~~s~~: ~~*(3-19-07)*~~( )

~~*a*~~i. Medication ~~*management*~~ *assistance, to the extent permitted under State law*; ~~*(3-19-07)*~~( )

~~*b*~~ii. Assistance with activities of daily living; (3-19-07)

~~*c*~~iii. Meals, including special diets; (3-19-07)

~~*d*~~iv. Housekeeping; (3-19-07)

~~*e*~~v. Laundry; (3-19-07)

~~*f*~~vi. Transportation; (3-19-07)

~~*g*~~vii. Opportunities for socialization; (3-19-07)

~~*h*~~viii. Recreation; and (3-19-07)

~~*i*~~ix. Assistance with personal finances. (3-19-07)

~~*j*~~x. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

~~*k*~~xi. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

b. Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Rules Governing Certified Family Homes," that

include: ( )

i. *M*edication *assistance, to the extent permitted under State law*; ( )

ii. Assistance with activities of daily living; ( )

iii. Meals, including special diets; ( )

iv. Housekeeping; ( )

v. Laundry; ( )

vi. Transportation; ( )

vii. Recreation; and ( )

viii. Assistance with personal finances. ( )

ix. Administrative oversight must be provided for all services provided or available in this setting. ( )

x. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. ( )

03. ~~*Assistive Technology*~~ Specialized Medical Equipment and Supplies. ~~*Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment.~~ ~~(3-19-07)~~( )

a. Specialized medical equipment and supplies include: ( )

i. Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and ( )

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. ( )

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. ( )

04. ~~*Assisted*~~ Non-Medical Transportation. ~~*Individual assistance with n*~~Non-medical transportation ~~*services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in*~~

~~order to~~ enables a waiver participant~~s~~ to gain access to waiver and other community services and resources. ~~(3-19-07)~~( )

a. ~~Assisted~~ Non-medical transportation ~~service~~ is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," ~~Sections 860 through 876,~~ and will not replace it. ~~(3-19-07)~~( )

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (3-19-07)

05. Attendant Care. ~~Attendant care services are those s~~Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal ~~care~~ assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services ~~may occur in the participant's home, community, work, school or recreational settings~~ are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. ~~(3-30-07)~~( )

~~**a.** To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized.~~ ~~(3-19-07)~~

~~**b.** The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety.~~ ~~(3-19-07)~~

06. Chore Services. Chore services include the following services ~~provided in Subsection 326.06.a. and 326.06.b. of this rule~~ when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: ~~(3-19-07)~~( )

a. Intermittent ~~A~~assistance may include the following. ~~(3-19-07)~~( )

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in the~~ir~~ home. ~~(3-19-07)~~( )

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, care~~taker~~giver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. ~~(3-19-07)~~( )

d. In the case of rental property, the landlord's responsibility ~~of the landlord, pursuant to~~ under the lease agreement~~,~~ will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. ~~(3-19-07)~~( )

07. ~~Adult~~ Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are ~~I~~in-home services to ~~i~~ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the ~~major~~ primary responsibility is to provide companionship and be there in case they are needed. ~~(3-19-07)~~( )

08. Consultation. Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant~~'~~ and the participant's family. Services ~~to the provider are for the purpose of~~ include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. ~~(3-19-07)~~( )

09. Dental Services. Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. (7-1-12)T

10. Home Delivered Meals. Home delivered meals are ~~*M*~~meals ~~*which*~~ that are ~~*designed*~~ delivered to the participant's home to promote adequate participant nutrition~~. *through the provision and home delivery of o*~~One (1) to two (2) meals per day~~. *Home delivered meals are limited to*~~ may be provided to a participant~~s~~ who: ~~*(3-19-07)*~~( )

a. Rents or owns ~~*their own*~~ a home; ~~*(3-19-07)*~~( )

b. ~~*Are*~~ Is alone for significant parts of the day; ~~*(3-19-07)*~~( )

c. ~~*Have*~~ Has no ~~*regular*~~ care~~*taker*~~giver for extended periods of time; and ~~*(3-19-07)*~~( )

d. ~~*Are*~~ Is unable to prepare a ~~*balanced*~~ meal without assistance. ~~*(3-19-07)*~~( )

11. Homemaker Services. ~~*Assistance to the participant with light housekeeping,*~~ Homemaker services consist of performing for the participant, or assisting him with, or both, the following tasks: laundry, ~~*assistance with*~~ essential errands, meal preparation, and other ~~*light*~~ routine housekeeping duties if there is no one else in the household capable of performing these tasks. ~~*(3-19-07)*~~( )

12. ~~*Home Modifications*~~ Environmental Accessibility Adaptations. Environmental accessibility adaptations include ~~*M*~~minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: ~~*(3-19-07)*~~( )

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems ~~*which*~~ that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but ~~*will*~~ must exclude those adaptations or improvements to the home ~~*which*~~ that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. ~~*(3-19-07)*~~( )

b. Unless otherwise authorized by the Department, ~~*P*~~permanent environmental modifications are limited to ~~*modifications to*~~ a home ~~*owned by the participant or the participant's family and the home*~~ that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. ~~*(3-19-07)*~~( )

c. ~~*Portable or Non-Stationary Modifications.*~~ Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. ~~*(3-19-07)*~~( )

13. Personal Emergency Response System (PERS). ~~*A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems.*~~ PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility.

The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. ~~PERS are~~ This service is limited to participants who: ~~(3-19-07)~~( )

a. Rent or own ~~their~~ a home, or live with unpaid ~~relatives~~ caregivers;~~(3-19-07)~~( )

b. Are alone for significant parts of the day; (3-19-07)

c. Have no care~~taker~~giver for extended periods of time; and ~~(3-19-07)~~( )

d. Would otherwise require extensive, routine supervision. (3-19-07)

~~**14. Psychiatric Consultation**. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis.~~ ~~(3-19-07)~~

1~~5~~4. **Respite Care**. ~~Occasional~~ Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other ~~waiver~~ services ~~which~~ that are duplicative in nature. Respite care services provided under this waiver ~~will~~ do not include room and board payments. Respite care services may be provided in the participant's residence, a certified family home, a developmental disabilities agency, a residential care or assisted living facility, or an adult day health facility. ~~(3-19-07)~~( )

1~~6~~5. **Skilled Nursing ~~Services~~**. Skilled nursing includes ~~I~~intermittent or continuous oversight, training, or skilled care ~~which~~ that is within the scope of the Nurse Practice Act. ~~and as s~~Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. ~~Nursing services may include but are not limited to:~~ ~~(3-19-07)~~( )

~~**a.** The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material;~~ ~~(3-19-07)~~

~~**b.** The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning.~~ ~~(3-19-07)~~

~~**c.** Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis;~~ ~~(3-19-07)~~

~~**d.** Injections;~~ ~~(3-19-07)~~

~~**e.** Blood glucose monitoring; and~~ ~~(3-19-07)~~

~~***f.*** *Blood pressure monitoring.* *(3-19-07)*~~

1~~7~~6. Habilitation. Habilitation services ~~*consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to*~~ assist the participant~~s~~ to reside ~~*successfully in their own homes, with their families, or in alternate family homes*~~ as independently as possible in the community, or maintain family unity. ~~*(3-30-07)*~~( )

a. Residential habilitation. Residential habilitation services ~~*assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity*~~ consist of an integrated array of individually tailored services and supports furnished to eligible participants. ~~*Habilitation services include training in one (1) or more of the following areas*~~ These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: ~~*(3-30-07)*~~( )

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

vii. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person’s primary

caregiver(s) are unable to accomplish on his or her own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. ( )

b. Day habilitation. Day ~~re~~habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day ~~re~~habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day ~~re~~habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ~~(4-2-08)~~( )

1~~8~~7. **Supported Employment**. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained ~~by RMS~~ in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. ~~(3-30-07)~~( )

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program~~s~~, payments that are passed through to beneficiaries of a supported employment program~~s~~, or payments for vocational training that is not directly related to a waiver participant's supported employment program. ~~(3-30-07)~~( )

~~***19. Behavior Consultation or Crisis Management.*** *Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis.* (3-30-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED OR DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the ~~*Regional Medicaid Services*~~ Department. The ~~*RMS*~~ Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by ~~*RMS*~~ Department staff or a contractor. The ~~*RMS*~~ Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. ~~*(3-30-07)*~~( )

a. Services ~~*which*~~ that are not in the individual service plan approved by the ~~*RMS*~~ Department or its contractor are not eligible for Medicaid payment. ~~*(3-19-07)*~~( )

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the ~~*RMS*~~ Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. ~~*(3-19-07)*~~( )

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

04. Individual Service Plan. All waiver services must be authorized by the ~~*RMS*~~ Department or its contractor in the Region where the participant will be residing and services provided based on a written individual service plan. ~~*(3-30-07)*~~( )

a. The initial individual service plan is developed by the ~~*RMS*~~ Department or its contractor, based on the UAI, in conjunction with: ~~*(3-19-07)*~~( )

i. The waiver participant (with efforts made by the ~~*RMS*~~ Department or its contractor to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); ~~*(3-30-07)*~~( )

ii. The guardian, when appropriate; (3-30-07)

iii. The supervising nurse or case manager, when appropriate; and (3-19-07)

iv. Others identified by the waiver participant. (3-19-07)

b. The individual service plan must include the following: (3-19-07)

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)

iii. The providers of waiver services when known; (3-30-07)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)

v. The signature of the participant or his legal representative, agreeing to the plan. (3-19-07)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)

d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the ~~*RMS*~~ Department or its contractor prior to the payment of services. ~~*(3-19-07)*~~( )

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

05. Service Delivered Following a Written Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

a. The plan of care is developed by the plan of care team which includes: (3-30-07)

i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (3-30-07)

ii. The Department's administrative case manager; (3-30-07)

iii. The guardian when appropriate; (3-30-07)

iv. Service provider identified by the participant or guardian; and (3-30-07)

v. May include others identified by the waiver participant. (3-30-07)

b. The plan of care must be based on an assessment process approved by the Department. (3-30-07)

c. The plan of care must include the following: (3-30-07)

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)

iii. The providers of waiver services; (3-30-07)

iv. Goals to be addressed within the plan year; (3-30-07)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)

vi. The signature of the participant or his legal representative. (3-30-07)

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)

e. The Department's case manager monitors the plan of care and all waiver services. (3-30-07)

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)

06. Provider Records. Records will be maintained on each waiver participant. (3-19-07)

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Services provided during the visit; (3-19-07)

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the ~~*RMS*~~ Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. ~~*(3-19-07)*~~( )

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the ~~*RMS*~~ Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. ~~*(3-19-07)*~~( )

c. The individual service plan initiated by the ~~*RMS*~~ Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the ~~*RMS*~~ Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. ~~*(3-19-07)*~~( )

d. *Record requirements for participants in residential care or assisted living facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho."* ( )

e. *Record requirements for participants in certified family homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes."* ( )

07. Provider Responsibility for Notification. The service provider is responsible to notify the ~~*RMS*~~ Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~*(3-19-07)*~~( )

08. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

09. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED OR DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the

following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health, transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals~~, *and behavior consultants*~~ must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's ~~*approved*~~ Aged and Disabled waiver as approved by CMS. ~~*(3-19-07)*~~( )

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks~~.~~," ~~*including:*~~ ~~*(4-2-08)*~~( )

~~*i. Companion services;*~~ ~~*(4-2-08)*~~

~~ii. Chore services; and~~ ~~(4-2-08)~~

~~iii. Respite care services.~~ ~~(4-2-08)~~

04. Specialized Medical Equipment ~~Provider Qualifications~~ and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs.
~~(3-19-07)~~( )

05. Skilled Nursing Service ~~Provider Qualifications~~. Skilled ~~N~~nursing ~~S~~service ~~P~~providers must be licensed in Idaho as a~~n R.N.~~ registered nurse or ~~L.P.N.~~ licensed practical nurse in ~~Idaho~~ good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."
~~(3-19-07)~~( )

~~**06. Psychiatric Consultation Provider Qualifications**. Psychiatric Consultation Providers must have:~~ ~~(3-19-07)~~

~~**a.** A master's degree in a behavioral science;~~ ~~(3-19-07)~~

~~**b.** Be licensed in accordance with state law and regulations; or~~ ~~(3-19-07)~~

~~**c.** A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems.~~ ~~(4-2-08)~~

~~**d.** Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."~~ ~~(4-2-08)~~

0~~7~~6. Consultation Services. Consultation ~~S~~services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/ family members in hiring, firing, training, and supervising their own care providers.
~~(3-19-07)~~( )

0~~8~~7. Adult Residential Care ~~Providers~~. Adult ~~R~~residential ~~C~~care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," ~~and~~ or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho."
~~(4-2-08)~~( )

0~~9~~8. Home Delivered Meals. Providers of home delivered meals must be a public

agency or private business, and must ~~be capable of~~ exercise supervision to ensure that:
~~(3-19-07)~~( )

~~**a.** Supervising the direct service;~~ ~~(3-19-07)~~

~~**b**~~**a.** ~~Providing assurance that~~ ~~e~~Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; ~~(3-19-07)~~( )

~~**c**~~**b.** Meals are ~~D~~deliver~~ing~~ed ~~the meals~~ in accordance with the service plan ~~for care~~, in a sanitary manner, and at the correct temperature for the specific type of food; ~~(3-19-07)~~( )

~~**d**~~**c.** ~~Maintaining~~ ~~d~~Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; ~~and~~ ~~(3-19-07)~~( )

~~**e**~~**d.** ~~Being~~ The agency or business is inspected and licensed as a food establishment ~~by the district health department.~~ *under IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments";* ~~(3-19-07)~~( )

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and ( )

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. ( )

~~**1**~~**09. Personal Emergency Response Systems**. Personal emergency response system ~~P~~providers must demonstrate that the devices installed in a waiver participant's home~~s~~ meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. ~~(3-19-07)~~( )

1~~**1**~~**0. Adult Day ~~Care~~ Health**. ~~Facilities that p~~Providers of adult day ~~care~~ health must ~~be maintained in safe and sanitary manner.~~ meet the following requirements: ~~(3-30-07)~~( )

a. ~~Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served.~~ Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ~~(3-19-07)~~( )

b. ~~Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served.~~ Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes." ~~(3-30-07)~~( )

c. ~~Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06,~~

~~"Criminal History and Background Checks History and Background Checks."~~ Services provided in a residential adult living facility must be provided in a residential adult living facility that meets the standards identified in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." ~~(4-2-08)~~( )

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ( )

f. Adult day health providers who provide direct care or services must be free from communicable disease. ( )

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

~~**12. Assistive Technology**. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need.~~ ~~(3-19-07)~~

1~~3~~1. ~~**Assisted**~~ **Non-Medical Transportation Services**. ~~See Subsection 329.03 of this rule for provider qualifications.~~ Providers of non-medical transportation services must: ~~(3-19-07)~~( )

a. Possess a valid driver's license; ( )

b. Possess valid vehicle insurance; and ( )

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

1~~4~~2. **Attendant Care**. ~~See Subsection 329.03 of this rule for provider qualifications.~~ Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ~~(4-2-08)~~( )

1~~5~~3. **Homemaker Services**. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily

complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ~~(4-2-08)~~( )

16~~4~~. ~~Home Modifications~~ Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ~~(3-19-07)~~( )

17~~5~~. Residential Habilitation Supported Living ~~Provider Qualifications~~. When ~~R~~residential habilitation ~~supported living~~ services ~~must be~~ are provided by an agency, ~~that is capable of~~ the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and supervis~~ing~~e the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: ~~(3-29-12)~~( )

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of ~~care~~ service; ~~(3-30-07)~~( )

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable disease~~s~~; ~~(3-30-07)~~( )

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" ~~(4-2-08)~~( )

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. ~~Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule.~~ ~~(3-30-07)~~( )

~~*c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services qualified by a program coordinator who is approved by the Department.* (3-29-12)~~

~~d~~c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: ~~(3-30-07)~~( )

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

~~e~~d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

f~~f~~e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed~~;~~. ~~and~~ ~~(3-30-07)~~( )

~~**18. Residential Habilitation Program Coordination for Certified Family Home Providers**. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes" and must receive residential habilitation program coordination from a qualified program coordinator approved by the Department. Non-compliance with the certification process is cause for termination of the provider agreement or contract.~~ ~~(3-29-12)~~

1~~9~~6. **Day ~~Reh~~Habilitation ~~Provider Qualifications~~**. Providers of day ~~re~~habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day ~~re~~habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(4-2-08)~~( )

17. Respite Care. Providers of respite care services must meet the following minimum qualifications: ( )

a. Have received care giving instructions in the needs of the person who will be provided the service; ( )

b. Demonstrate the ability to provide services according to a plan of service; ( )

c. Be free of communicable disease; and ( )

d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

~~20~~18. Supported Employment ~~Service Providers~~. Supported employment services must be provided by an agency ~~capable of~~ that supervis~~ing~~es the direct service and ~~be~~ is accredited by the Commission on Accreditation of Rehabilitation Facilities~~;~~ or other comparable standards~~;~~, or meet State requirements to be a State-approved provider~~, and have taken a traumatic brain injury training course approved by the Department~~. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." Providers must also take a traumatic brain injury training course approved by the Department. ~~(4-2-08)~~( )

~~**21. Behavior Consultation or Crisis Management Service Providers**. Behavior consultation or crisis management providers must meet the following:~~ ~~(3-30-07)~~

~~*a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study;* (3-30-07)~~

~~*b. Be a licensed pharmacist; or* (3-30-07)~~

~~*c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and* (3-30-07)~~

~~*d. Take a traumatic brain injury training course approved by the Department.* (3-30-07)~~

~~*e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services.* (3-30-07)~~

~~*f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."* (4-2-08)~~

19. **Chore Services**. Providers of chore services must meet the following minimum qualifications: ( )

a. Be skilled in the type of service to be provided; and ( )

b. Demonstrate the ability to provide services according to a plan of service. ( )

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

2~~2~~0. Dental Services. Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-12)T

330. AGED OR DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT. The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (3-19-07)

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department, or as agreed upon by the Department's contractor and the provider, depending on the type of service provided. Adult residential care will be paid on a per

diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. ~~(3-19-07)~~( )

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department or its contractor. Billing instructions will be provided by the Department's payment system contractor. ~~(3-19-07)~~( )

03. Calculation of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services ~~*which*~~ consist of an integrated array of individually tailored services and supports furnished to eligible participants. ~~*which*~~ These services and supports are designed to assist the~~*m*~~ participants to reside successfully in their own homes, with their families, or ~~*alternate*~~ in certified family homes. The services and supports that may be furnished consist of the following: ~~(3-19-07)~~( )

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are

merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services ~~*which are heavy household maintenance and minor home repairs*~~ include the following services when necessary to maintain the functional use of the home ~~*and*~~ or to provide a clean, sanitary, and safe environment. ~~*Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.*~~ ~~*(3-19-07)*~~( )

a. Intermittent Assistance may include the following: ( )

i. Yard maintenance; ( )

ii. Minor home repair; ( )

iii. Heavy housework; ( )

iv. Sidewalk maintenance; and ( )

v. Trash removal to assist the participant to remain in the home. ( )

b. Chore activities may include the following: ( )

i. Washing windows; ( )

ii. Moving heavy furniture; ( )

iii. Shoveling snow to provide safe access inside and outside the home; ( )

iv. Chopping wood when wood is the participant's primary source of heat; and ( )

v. Tacking down loose rugs and flooring. ( )

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. ( )

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. ( )

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver ~~will~~ do not include room and board payments. ~~Respite care services are limited to participants who reside with non-paid caregivers.~~ Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. ~~(3-19-07)~~( )

04. Supported Employment. Supported employment ~~which is~~ consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability~~;~~. ~~and who, b~~Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. ~~(3-19-07)~~( )

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation ~~will~~ must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. ~~(3-19-07)~~( )

b. Federal Financial Participation (FFP) ~~will~~ cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that ~~is~~ are not directly related to a waiver participant's supported employment program. ~~(3-19-07)~~( )

05. Non-Medical Transportation. ~~*Transportation services which are services offered in order to*~~ Non-medical transportation enables a waiver participant~~s~~ to gain access to waiver and other community services and resources ~~*required by the plan of service*~~. ( )

a. ~~*This service*~~ Non-medical transportation is offered in addition to medical transportation required ~~*under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must*~~ in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace ~~*them*~~ it. ( )

b. Whenever possible, family, neighbors, friends, or community agencies ~~*which*~~ who can provide this service without charge or public transit providers will be utilized.
~~*(3-19-07)*~~( )

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations ~~*which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which*~~ include minor housing adaptations that are necessary to enable the ~~*individual*~~ participant to function with greater independence in the home, ~~*and*~~ or without which, the ~~*waiver*~~ participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: ( )

a. ~~*t*~~The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems ~~*which*~~ that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home ~~*which*~~ that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. ~~*All services must be provided in accordance with applicable State or local building codes.*~~ ( )

b. Unless otherwise authorized by the Department, ~~*P*~~permanent environmental modifications are limited ~~*to modifications*~~ to a home ~~*rented or owned by the participant or the participant's family when the home*~~ that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. ( )

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.
~~*(3-19-07)*~~( )

07. Specialized Medical Equipment and Supplies. ( )

a. Specialized medical equipment and supplies include: ( )

i. ~~*d*~~Devices, controls, or appliances~~, *specified in the plan of service which*~~ that enable a participant~~s~~ to increase ~~*their*~~ his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which ~~*they*~~ he lives~~.~~; and ( )

ii. ~~*They also include i*~~Items necessary for life support, ancillary supplies and

equipment necessary ~~to~~ for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. ( )

b. Items reimbursed with waiver funds ~~must be~~ are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and ~~must~~ exclude those items ~~which~~ that are not of direct medical or remedial benefit to the participant. ~~All items must meet applicable standards of manufacture, design and installation.~~ ~~(3-19-07)~~( )

08. Personal Emergency Response System (PERS). ~~Personal Emergency Response Systems (~~PERS~~)~~ ~~which~~ is an electronic device that enables a waiver participant to secure help in an emergency. ~~may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems.~~ The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. ~~PERS are~~ This service is limited to participants who: ( )

a. ~~r~~Rent or own ~~their~~ a home, or live with unpaid caregivers; ( )

b. ~~who a~~Are alone for significant parts of the day~~.~~; ( )

c. ~~h~~Have no ~~regular~~ care~~taker~~giver for extended periods of time; and ( )

d. ~~who w~~Would otherwise require extensive, routine supervision. ~~(3-19-07)~~( )

09. Home Delivered Meals. Home delivered meals ~~which~~ are meals that are ~~designed~~ delivered to a participant's home to promote adequate ~~wavier~~ participant nutrition. ~~through the provision and home delivery of o~~One (1) to two (2) meals per day may be provided~~. Home delivered meals are limited~~ to a participant~~s~~ who: ( )

a. ~~r~~Rents or owns ~~their own~~ a home~~.~~; ( )

b. ~~who are~~ Is alone for significant parts of the day; ~~and~~ ( )

c. ~~have~~ Has no ~~regular~~ care~~taker~~giver for extended periods of time~~.~~; and ~~(3-19-07)~~( )

d. Is unable to prepare a meal without assistance. ( )

10. Skilled Nursing. ~~Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are~~ Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. ~~and are~~ Such care must be provided by a licensed ~~professional (RN)~~ registered nurse, or licensed practical nurse, ~~(LPN)~~ under the supervision of a~~n RN,~~ registered nurse licensed to practice in Idaho. ~~(3-19-07)~~( )

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants

who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day ~~*Care*~~ Health. ~~*Adult day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service.*~~ Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Adult day ~~*Care*~~ health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy~~, or IBI~~, and occupational therapy~~, or IBI~~. ~~*(3-19-07)*~~( )

~~***a.*** *Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."* *(7-1-11)*~~

~~***b.*** *Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."* *(7-1-11)*~~

13. Dental Services. Dental services include exams radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. (7-1-12)T

14. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

15. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/

ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and must ~~*be capable of*~~ supervis~~*ing*~~e the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: ~~*(3-19-07)*~~( )

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a~~*n*~~ plan of service; ~~*(3-19-07)*~~( )

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable disease~~*s*~~; ~~*(3-19-07)*~~( )

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. ~~*Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007.*~~ ~~*(3-19-07)*~~( )

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which

require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-29-12)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

02. Residential Habilitation -- Certified Family Home (CFH). (3-29-12)

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides. (3-29-12)

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (3-29-12)

i. Be at least eighteen (18) years of age; (3-29-12)

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-29-12)

iii. Have current CPR and First Aid certifications; (3-29-12)

iv. Be free from communicable disease~~s~~; ~~(3-29-12)~~( )

v. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. (3-29-12)

vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and (3-29-12)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-29-12)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (3-29-12)

i. Purpose and philosophy of services; (3-29-12)

ii. Service rules; (3-29-12)

iii. Policies and procedures; (3-29-12)

iv. Proper conduct in relating to waiver participants; (3-29-12)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-29-12)

vi. Participant rights; (3-29-12)

vii. Methods of supervising participants; (3-29-12)

viii. Working with individuals with developmental disabilities; and (3-29-12)

ix. Training specific to the needs of the participant. (3-29-12)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (3-29-12)

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (3-29-12)

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (3-29-12)

iii. Feeding; (3-29-12)

iv. Communication; (3-29-12)

v. Mobility; (3-29-12)

vi. Activities of daily living; (3-29-12)

vii. Body mechanics and lifting techniques; (3-29-12)

viii. Housekeeping techniques; and (3-29-12)

ix. Maintenance of a clean, safe, and healthy environment. (3-29-12)

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (3-29-12)

03. Chore Services. Providers of chore services must meet the following minimum

qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

04. Respite Care. Providers of respite care services must meet the following minimum qualifications: ~~(3-19-07)~~( )

~~**a.** Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)~~

~~**b**~~**a.** Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

~~**c**~~**b.** Demonstrate the ability to provide services according to a~~n~~ plan of service; ~~(3-19-07)~~( )

~~**d.** Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)~~

~~**e.** Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)~~

~~**f**~~**c.** Be free of communicable disease~~s.~~; and ~~(3-19-07)~~( )

~~**g**~~**d.** Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05. Supported Employment. Supported employment services must be provided by an agency ~~capable of~~ that supervis~~ing~~es the direct service and ~~be~~ is accredited by the Commission on Accreditation of Rehabilitation Facilities~~;~~ or other comparable standards~~;~~, or meets State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(4-2-08)~~( )

06. Non-Medical Transportation. Providers of non-medical transportation services must: ~~(3-19-07)~~( )

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

07. Environmental Accessibility Adaptations. ~~*Environmental accessibility adaptations services must:*~~ All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ~~*(3-19-07)*~~( )

~~***a.*** *Be done under a permit, if required; and* *(3-19-07)*~~

~~***b.*** *Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes.* *(3-19-07)*~~

08. Specialized Medical Equipment and Supplies. ~~*Specialized Equipment and Supplies purchased under this service must:*~~ Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. ~~*(3-19-07)*~~( )

~~***a.*** *Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and* *(3-19-07)*~~

~~***b.*** *Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment.* *(3-19-07)*~~

09. Personal Emergency Response System. Personal emergency response system~~s~~ ~~*(PERS)*~~ providers must demonstrate that the devices installed in a waiver participant's home~~s~~ meet Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards. ~~*(3-19-07)*~~( )

10. Home Delivered Meals. ~~*Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must*~~ Providers of home-delivered meals must be a public agency or private business, and must exercise supervision to ensure that: ~~*(7-1-11)*~~( )

a. ~~*Provide assurances that e*~~Each meal meets one-third (1/3) of the Recommended ~~*Dietary*~~ Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council ~~*or meet physician ordered individualized therapeutic diet requirement*~~ of the National Academy of Sciences; ~~*(3-19-07)*~~( )

b. ~~*Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week;*~~ Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ~~*(3-19-07)*~~( )

c. ~~*Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. grade for each specific food served*~~ A Registered Dietitian

documents the review and approval of menus, menu cycles, and any changes or substitutions; and (3-19-07)( )

~~**d.** *Provide documentation of current driver's license for each driver; and* (3-19-07)~~

~~**e**~~**d.** ~~*Must be*~~ The agency or business is inspected and licensed as a food establishment ~~*by the District Health Department*~~ *under IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments."* ~~(3-19-07)~~( )

11. Skilled Nursing. Skilled ~~N~~nursing service providers must ~~*provide documentation of current*~~ be licensed in Idaho ~~*licensure*~~ as a ~~*licensed professional*~~ registered nurse ~~*(RN)*~~ or licensed practical nurse ~~*(LPN)*~~ in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-19-07)~~( )

12. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work ~~*for a provider agency capable of supervising the direct service or work*~~ under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and ~~(3-19-07)~~( )

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

13. Adult Day ~~*Care*~~ Health. Providers of adult day ~~*care*~~ health ~~*services must notify the Department or its contractor for residential habilitation program coordination, on behalf of the participant, if the adult day care is provided in a certified family home other than the participant's primary residence. The adult day care provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and*~~ must meet the following ~~*minimum qualifications*~~ requirements: ~~(3-29-12)~~( )

a. ~~*Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people;*~~ Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; ~~*(3-19-07)*~~( )

b. ~~*Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service;*~~ Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes"; ~~*(3-19-07)*~~( )

~~***c.*** *Be free from communicable disease;* *(3-19-07)*~~

~~***d***~~**c.** Adult day ~~*care*~~ health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; ~~*(4-2-08)*~~( )

d. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ( )

e. ~~*Demonstrate knowledge of infection control methods; and*~~ Adult day health providers who provide direct care or services must be free from communicable disease. ~~*(3-19-07)*~~( )

~~***f.*** *Agree to practice confidentiality in handling situations that involve waiver participants.* *(3-19-07)*~~

14. Dental Services. Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-12)T

15. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1203

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Idaho Department of Health and Welfare implemented the Children's System Redesign on July 1, 2011. Under the redesign, the Department is moving from a one-size-fits-all system that was only able to deliver therapy, to a system that provides a continuum of care based on the child's level of need. The new array of redesign benefits replaces developmental therapy and intensive behavioral intervention (IBI) services currently available under the State Plan.

Additionally, rules pertaining to the children's redesign services were approved by the Idaho Legislature during the 2011 legislative session. To transition children from developmental therapy and IBI to the redesign system, the Legislature approved a phased implementation plan to enroll children into the redesign according to their birthdays. The phased implementation plan has required the Department to operate both the old and new systems concurrently over the span of the transition year. The intent of keeping the old benefits in place (developmental therapy and IBI) was to ensure that families have services until their designated transition time to avoid any gap in services for their child.

To complete the transition to the redesigned system, rule changes are being made to remove the old developmental disability agency services.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. The change that was made removes a reference to IBI that should have been removed from the proposed rule as it published in October. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 356 through 410**.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on

the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to the state general fund. This is a cost-neutral program that has been approved the Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lauren Ertz at (208) 287-1169.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

October 17, 2012 6:00 p.m. (MDT Time)	October 17, 2012 6:00 p.m. (MDT Time)	October 17, 2012 6:00 p.m. (PDT Time)
1720 Westgate Dr. Suite A Boise, Idaho 83704	**421 Memorial Drive Pocatello, Idaho 83201**	**2195 Ironwood Court Coeur d'Alene, Idaho 83814**

If you are unable to attend a public hearing in any of the physical locations listed above, you can join the Boise public hearing from anywhere in the state via teleconference.

Teleconference number: 1-888-706-6468

Participant Code: 526505

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 Department of Health and Welfare implemented the Children's System Redesign on July 1, 2011. Under the redesign, the Department is moving from a one-size-fits-all system that was only able to deliver therapy, to a system that provides a continuum of care based on the child's level of need. The new array of redesign benefits replaces developmental therapy and intensive behavioral intervention (IBI) services currently available under the State Plan.

Additionally, rules pertaining to the children's redesign services were approved by the Idaho Legislature during the 2011 legislative session. To transition children from developmental therapy and IBI to the redesign system, the Legislature approved a phased implementation plan to enroll children into the redesign according to their birthdays. The phased implementation plan has required the Department to operate both the old and new systems concurrently over the span of the transition year. The intent of keeping the old benefits in place (developmental therapy and IBI) was to ensure that families have services until their designated transition time to avoid any gap in services for their child.

To complete the transition to the redesigned system, rule changes are needed to remove the old developmental disability agency services. Specifically, the following changes are being made:

1. Remove old children's developmental disability agency services from chapter.
2. Add Idaho Infant Toddler Program to the chapter as an allowable provider for children's DD services.
3. Add clarifications to the new Children's System Redesign rules.
4. Remove children's developmental disability service coordination. Children's DD service coordination is being replaced with case management delivered by the Department under the redesigned system.

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

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

There is no anticipated fiscal impact to the state general fund. This is a cost-neutral program that has been approved the Legislature.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted on June 20, 2012. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 6, 2012, Idaho Administrative Bulletin, **Volume 12-6, pages 22 and 23**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

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 October 26, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1203

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

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

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

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

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

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

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

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

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

c. A & D Wavier Services as described in Sections 320 through 330 of these rules.

(3-30-07)

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

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

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

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

~~**b.**~~ **c.** ~~*Behavioral Health Prior Authorization*~~ Adult Developmental Disabilities Services as described in Sections 507 through 520, and 649 through 657 of these rules. ~~*(3-19-07)*~~( )

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

~~***215. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH LANGUAGE PATHOLOGY SERVICES.***~~

~~*In addition to the providers listed at IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 730 through 739, physical therapy, occupational therapy, and speech-language pathology services are covered under these rules when provided by a Developmental Disabilities Agencies.* *(4-2-08)*~~

21~~6~~5. - 219. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

511. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.

The scope of these rules defines prior authorization for the following Medicaid developmental disability services for adults: (3-29-12)

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

02. Developmental ~~*Disabilities Agency Services*~~ Therapy. Developmental ~~*Disabilities Agency services*~~ therapy as described in Sections 649 through 65~~9~~7 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; and ~~*(7-1-11)*~~( )

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of ~~*DDA services*~~ developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. ~~*(3-29-12)*~~( )

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. ( )

b. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. ~~*(3-29-12)*~~( )

~~***b.*** *A medical social and developmental history for children is required when the child is accessing DDA services for the first time, and must reflect accurate information about the participant's status.* *(3-29-12)*~~

~~*c. After the initial medical social development history for children, additional Medical Social and Development History services for children will be reimbursed if a qualified professional determines that it no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules.* (3-29-12)~~

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. ~~(3-19-07)~~

~~*a.*~~ The SIB-R for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. ~~(3-29-12)~~( )

~~*b. The SIB-R for children is required for all children accessing DDA services for the first time.* (3-29-12)~~

~~*c. After the initial SIB-R assessment for children, additional SIB-R assessments will be reimbursed if a qualified professional determines that the assessment no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules.* (3-29-12)~~

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be

submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services ~~*provided outside of a Developmental Disabilities Agency (DDA)*~~. ~~*(4-2-08)*~~( )

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews. (3-29-12)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

08. Informed Consent. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

09. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (3-29-12)

11. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d. of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): DEFINITIONS.
For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. (7-1-11)

01. Assessment. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. (7-1-11)

02. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. (7-1-11)

03. Child. A person who is under the age of eighteen (18) years. (7-1-11)

04. Family. The participant and his parent(s) or legal guardian. (7-1-11)

05. Family-Centered Planning Process. A process facilitated by the plan developer, by which the family-centered planning team collaborates with the participant to develop the plan of service. (7-1-11)

06. Family-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the child participant (unless otherwise determined by the family-centered planning team), the parent or legal guardian and the plan developer. The family-centered planning team may include others identified by the family or agreed upon by the family and the Department as important to the process. (7-1-11)

07. ICF/ID. Intermediate care facility for persons with intellectual disabilities. (7-1-11)

08. Individualized Family Service Plan (IFSP). An initial or annual plan of service, developed by the Department or its designee, for providing early intervention services to children from birth up to ~~age~~ three (3) years of age (36 months). This plan must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C. The IFSP may serve as the plan of service if it meets all of the components of the plan of service. The IFSP may also serve as a program implementation plan. ~~(7-1-11)~~( )

09. Level of Support. The amount of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-11)

10. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (7-1-11)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports based on a family-centered planning process. (7-1-11)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (7-1-11)

13. Plan of Service. An initial or annual plan that identifies all services and supports based on a family-centered planning process, and which is developed for providing DD services to children birth through seventeen (17) years of age. (7-1-11)

14. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

15. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by

Sections 520 and 528 these rules. (7-1-11)

16. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

17. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-11)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-11)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-11)

21. Services. Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

523. ~~*TRANSITION TO NEW CHILDREN'S DEVELOPMENTAL DISABILITY BENEFITS.*~~ (RESERVED)

~~***01. Phase in Schedule**. To transition to the new benefits under Sections 520 through 528, Sections 660 through 666, and Sections 680 through 686 of these rules, a child will be phased in to the new benefits by order of his birthdate.* (7-1-11)~~

~~***02. Notification**. During the phased implementation, the Department will notify a family three (3) months prior to their child's birthdate.* (7-1-11)~~

~~***03. New Applicants**. A new applicant entering the system will be enrolled in the new children's DD benefit programs.* (7-1-11)~~

~~***04. Opportunity for Early Enrollment**. A family may opt to transition their child to the new benefits prior to their child's birthdate. The Department will accept application for a family who chooses to opt-in early, but transitioning a child at his scheduled transition date will be the Department's top priority.* (7-1-11)~~

~~***05. Duplication of Services**. A child will not be able to receive both the new children's HCBS state plan option and children's waiver services listed in Section 660 through 666 and 680*

~~*through 688, at the same time he is receiving the old DDA services listed in Section 649 through 659.*~~ ~~*(7-1-11)*~~

(BREAK IN CONTINUITY OF SECTIONS)

526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PLAN OF SERVICE PROCESS.

In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or use a paid or non-paid plan developer to assist with plan development. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

01. Plan Development and Monitoring. Paid plan development and monitoring must be provided by the Department or its contractor. Non-paid plan development and monitoring may be provided by the family, or a person of their choosing, when this person is not a paid provider of services identified on the child's plan of service. (7-1-11)

02. Plan of Service Development. The plan of service must be developed with the parent or legal guardian, and the child participant (unless otherwise determined by the family-centered planning team). With the parent or legal guardian's consent, the family-centered planning team may include other family members or individuals who are significant to the participant. (7-1-11)

a. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

b. The plan of service must identify, at a minimum, the type of service to be delivered, goals to be addressed within the plan year, target dates, and methods for collaboration. (7-1-11)

03. No Duplication of Services. The plan developer must ensure that there is no duplication of services. (7-1-11)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan developer must meet face-to-face with the participant at least annually. Plan monitoring must include the following: (7-1-11)

a. Review of the plan of service with the parent or legal guardian to identify the current status of programs and changes if needed; (7-1-11)

b. Contact with service providers to identify barriers to service provision; (7-1-11)

c. Discuss with parent or legal guardian satisfaction regarding quality and quantity of services; and (7-1-11)

d. Review of provider status reviews. (7-1-11)

05. Provider Status Reviews. The service providers in Sections 664 and 684 of these rules must report to the plan monitor the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service. (7-1-11)

06. Informed Consent. The participant and his parent or legal guardian must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. (7-1-11)

07. ~~*Provider*~~ Program Implementation Plan. Providers of children's waiver services listed under Section 684 of these rules must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. ~~*(7-1-11)*~~( )

a. The implementation plan must be completed within fourteen (14) calendar days after the initial provision of service, and revised whenever participant needs change. (7-1-11)

b. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. (7-1-11)

08. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires a parent's or legal guardian's signature and may be subject to prior authorization by the Department. (7-1-11)

09. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-11)

a. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. (7-1-11)

b. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least ~~*forty-five*~~ ten (~~*45*~~10) calendar days prior to the expiration date of the current plan. Prior to this, the plan developer must: ~~*(7-1-11)*~~( )

i. Notify the providers who appear on the plan of service of the annual review date. (7-1-11)

ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. (7-1-11)

iii. Convene the family-centered planning team to develop a new plan of service. (7-1-11)

c. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. (7-1-11)

d. Adjustments to the Annual Budget and Services. The annual budget ~~*and services*~~ may be adjusted ~~*based on demonstrated outcomes, progress toward goals and objectives, and benefit of services*~~ when there are documented changes that may support placement in a different budget category as identified in Section 527 of these rules. Services may be adjusted at any time during the plan year. ~~*(7-1-11)*~~( )

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after at least a thirty (30) calendar day lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-11)

527. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis for services identified on the participant's plan of service and within the participant's individualized budget. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. (7-1-11)

01. Individualized Budget Methodology. The following five (5) categories are used when determining individualized budgets for children with developmental disabilities: (7-1-11)

a. HCBS State Plan Option. Children meeting developmental disabilities criteria. (7-1-11)

b. Children's DD Waiver - Level I. (7-1-11)

i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or (7-1-11)

ii. Children who have an overall age equivalency up to fifty-three percent (53%) of their chronological age when combined with a General Maladaptive Index between minus seventeen (-17), and minus twenty-one (-21) inclusive. (7-1-11)

c. Children's DD Waiver - Level II. (7-1-11)

i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; and (7-1-11)

ii. Have an autism spectrum disorder diagnosis. (7-1-11)

d. Children's DD Waiver - Level III. Children meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less. (7-1-11)

e. Act Early Waiver. (7-1-11)

i. Children age three (3) through six (6) meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less, and their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or (7-1-11)

ii. Children age three (3) through six (6) meeting ICF/ID level of care criteria who have an autism spectrum disorder diagnosis. (7-1-11)

02. Participant Notification of Budget Amount. The Department notifies each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. (7-1-11)

03. Annual Re-Evaluation. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes ~~*in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget*~~ that may support placement in a different budget category as identified in this rule. ~~*(7-1-11)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

634. -- 64~~7~~8. (RESERVED)

~~***648. INTRODUCTION TO DEVELOPMENTAL DISABILITIES AGENCIES SECTION.***~~
~~*Sections 649 through 659 of these rules include the requirements for developmental disabilities agencies delivering services to children and adults. The benefit requirements for developmental therapy, Intensive Behavioral Intervention (IBI), and other DDA services were moved from IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," to this section of rules. IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," has been rewritten and renamed to: IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA).*~~ ~~*(7-1-11)*~~

~~***01. Background of the Children's System Redesign.***~~ ~~*(7-1-11)*~~

~~***a.*** *In 2008, the Department began meeting with stakeholder groups to redesign developmental disabilities (DD) benefits for children. This project is known as the "Children's System Redesign." The Department will begin phased implementation of these redesigned benefits starting July 1, 2011. Implementation requirements are provided in Section 523 of these rules.* (7-1-11)~~

~~***b.*** *In order to phase in these new benefits as seamlessly as possible, the Department will continue to operate the current children's DD benefits concurrently with the redesigned children's DD benefits.* (7-1-11)~~

~~*i.* *The current children's DD benefits are found under Sections 649 to 659 of these rules.* (7-1-11)~~

~~*ii.* *The redesigned children's DD benefits are found under Sections 520 through 528, 660 through 666, and 680 through 686 of these rules.* (7-1-11)~~

~~***02.*** ***Developmental Disabilities Agency Services for Adults Age Eighteen and Older.*** *Current DDA services for adults have not been modified and are covered under Sections 649 to 659 of these rules.* (7-1-11)~~

649. DEVELOPMENTAL ~~*DISABILITIES AGENCIES (DDA)*~~ THERAPY.
~~*Under 42 CFR 440.130(d), t*~~The Department will pay for ~~*rehabilitative services including medical or remedial services*~~ developmental therapy provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. ~~*Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements.* (3-19-07)~~( )

650. DEVELOPMENTAL ~~*DISABILITIES AGENCY (DDA) SERVICES*~~ THERAPY: ELIGIBILITY.

~~***01.*** ***DDA Services Eligibility.*~~ Prior to receiving ~~*services*~~ developmental therapy in a DDA an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code be eighteen (18) years of age or older, and live in the community. ~~(7-1-11)~~( )

~~***02.*** ***Intensive Behavioral Intervention (IBI) Service Eligibility.*** *IBI is available to children with developmental disabilities through the month of their twenty-first birthday, who have the following characteristics:* (7-1-11)~~

~~***a.*** *Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of*

~~Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department; and~~ ~~(7-1-11)~~

~~**b.** A severe deficit, defined as equivalent to fifty percent (50%) or less of chronological age, in at least one (1) of the following areas:~~ ~~(7-1-11)~~

~~i. Verbal and nonverbal communication as evidenced by the SIB-R Social Interaction & Communication Skills cluster score;~~ ~~(7-1-11)~~

~~ii. Social interaction as evidenced by the SIB-R Social Interaction subscale score; or~~ ~~(7-1-11)~~

~~iii. Leisure and play skills as evidenced by the SIB-R Home/Community Orientation subscale score.~~ ~~(7-1-11)~~

651. ~~DDA SERVICES~~ DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental ~~disabilities agency services~~ therapy must be recommended by a physician or other practitioner of the healing arts. ~~The following therapy services are reimbursable when provided in accordance with these rules.~~ ~~(7-1-11)~~( )

~~**01. Required DDA Services**. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement.~~ ~~(7-1-11)~~

~~**a.** Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules.~~ ~~(7-1-11)~~

~~**b.** When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one.~~ ~~(7-1-11)~~

0~~2~~1. **Requirements to Deliver Developmental Therapy**. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy ~~services~~ must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an ~~comprehensive developmental~~ assessment completed prior to the delivery of developmental therapy. ~~Developmental therapy will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.~~ ~~(3-29-12)~~( )

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or ~~*mental*~~ developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ~~(7-1-11)~~( )

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-11)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. ~~(7-1-11)~~( )

~~***03. Psychotherapy Services.*** *The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service:* (7-1-11)~~

~~***a.*** *Individual psychotherapy;* (7-1-11)~~

~~***b.*** *Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and* (7-1-11)~~

~~***c.*** *Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time.* (7-1-11)~~

~~***d.*** *Psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered.* (3-29-12)~~

~~***e.*** *Psychotherapy services must be provided by one (1) of the following qualified professionals:* (7-1-11)~~

~~*i.* *Licensed Psychiatrist;* (7-1-11)~~

~~*ii.* *Licensed Physician;* (7-1-11)~~

~~*iii* *Licensed Psychologist;* (7-1-11)~~

~~*iv. Licensed Clinical Social Worker;* (7-1-11)~~

~~*v. Licensed Clinical Professional Counselor;* (7-1-11)~~

~~*vi. Licensed Marriage and Family Therapist;* (7-1-11)~~

~~*vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree;* (7-1-11)~~

~~*viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.e.i. through 651.03.e.vii. of this rule;* (7-1-11)~~

~~*ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists."* (7-1-11)~~

~~*x. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or* (7-1-11)~~

~~*xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners."* (7-1-11)~~

~~***04. Occupational Therapy Services**. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules.* (7-1-11)~~

~~***05. Physical Therapy Services**. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules.* (7-1-11)~~

~~***06. Speech-Language Pathology Services**. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Speech-language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules.* (7-1-11)~~

~~**07. Optional Services**. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, and Intensive Behavioral Intervention (IBI). All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (3-29-12)~~

~~**08. Pharmacological Management**. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency, and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (7-1-11)~~

~~**09. Psychiatric Diagnostic Interview**. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. (7-1-11)~~

~~**a.** Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. (7-1-11)~~

~~**b.** On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. (7-1-11)~~

~~**c.** Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: (7-1-11)~~

~~i. Psychiatrist; (7-1-11)~~

~~ii. Physician or other practitioner of the healing arts; (7-1-11)~~

~~iii. Psychologist; (7-1-11)~~

~~iv. Clinical social worker; or (7-1-11)~~

~~v. Clinical professional counselor. (7-1-11)~~

~~**10. Community Crisis Supports**. Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. (7-1-11)~~

~~**11. Intensive Behavioral Intervention**. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. (7-1-11)~~

~~***a.*** *IBI is limited to a lifetime limit of thirty-six (36) months.* *(7-1-11)*~~

~~***b.*** *The DDA must receive prior authorization from the Department prior to delivering IBI services.* *(7-1-11)*~~

~~***c.*** *IBI must only be delivered on an individualized, one-to-one (1 to 1) basis.* *(7-1-11)*~~

~~***d.*** *Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* *(3-29-12)*~~

~~***e.*** *After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services.* *(3-29-12)*~~

~~***f.*** *Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of this rule.* *(3-29-12)*~~

~~***g.*** *IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation.* *(3-29-12)*~~

~~1~~0**2. Excluded Services**. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

~~1~~0**3. Limitations on ~~*DDA Services*~~ Developmental Therapy**. ~~*DDA*~~ Developmental therapy ~~*services*~~ may not exceed the limitations as specified below. ~~*(3-29-12)*~~( )

a. ~~*The combination of therapy services listed in Subsections 651.02 through 651.06, and 651.11 of this rule*~~ Developmental therapy must not exceed twenty-two (22) hours per week. ~~*(3-29-12)*~~( )

b. Developmental ~~T~~therapy ~~*services listed in Subsections 651.02 through 651.06, and 651.11 of this rule,*~~ provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. ~~*(3-29-12)*~~( )

c. When a~~*n HCBS waiver*~~ participant ~~*under Sections 700 through 719 of these rules*~~ receives adult day ~~*care*~~ health as provided in Subsection 703.12 of these rules, the combination of adult day ~~*care*~~, health and developmental therapy ~~*and Occupational therapy*~~ must not exceed thirty (30) hours per week. ~~*(7-1-11)*~~( )

d. Only one (1) type of therapy ~~*service*~~ will be reimbursed during a single time period by the Medicaid program. ~~*No*~~ Developmental therapy ~~*services*~~ will not be reimbursed during periods when the participant is being transported to and from the agency. ~~*(7-1-11)*~~( )

~~***REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES PROVIDING SERVICES***~~
~~***(Sections 652 through 659)***~~

652. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR ~~*A DDA PROVIDING SERVICES TO PERSONS EIGHTEEN YEARS OF AGE OR OLDER*~~ INDIVIDUALS WITH AN ISP.

~~*This Section does not apply to adults who receive IBI or additional DDA services prior authorized under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." DDAs must comply with the requirements under Section 653 of these rules for those adults.* *(7-1-11)*~~

01. Eligibility Determination. Prior to the delivery of ~~*any DDA services*~~ developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, ~~*for DDA services*~~ be eighteen (18) years of age or older, and live in the community. ~~*(7-1-11)*~~( )

~~***a.*** *For persons seeking Medicaid-funded DDA services who are eighteen (18) years of age or older, the Department or its designee determines eligibility for services.* *(7-1-11)*~~

~~***b.*** *For persons eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.01 of these rules.* *(7-1-11)*~~

02. Intake. Prior to the delivery of developmental therapy: ~~*(7-1-11)*~~( )

a. ~~*For Medicaid participants eighteen (18) years of age or older, prior to the delivery of any Medicaid-funded DDA services:* *(7-1-11)*~~

~~*i.* *The Department or its designee will have provided the*~~ A DDA ~~*with*~~ will obtain a participant's current medical, social, and developmental information~~*; and*~~ from the Department or its designee. ~~*(7-1-11)*~~( )

~~*ii*~~**b.** The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. Developmental therapy provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. ~~*(7-1-11)*~~( )

~~***b.*** *Participants eighteen (18) years of age or older receiving DDA services and who are using the Home and Community Based Services (HCBS) Waiver for the Aged and Disabled (A&D), State Plan PCS, or are living in a nursing facility must:* *(7-1-11)*~~

~~*i. Have DDA services prior authorized by the Department or its designee; and* (7-1-11)~~

~~*ii. DDAs must complete an Individual Program Plan (IPP) that meets the standards described in Subsections 653.04 through 653.06 of these rules. IPPs for these individuals do not require the signature of a physician or other practitioner of the healing arts.* (7-1-11)~~

~~***c.*** *For participants eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.02 of these rules.* (7-1-11)~~

~~***03. Assessments.*** *Requirements for assessments are found under Subsections 655.01 through 655.06 of these rules.* (7-1-11)~~

~~***04. Individual Service Plan (ISP).*** *For participants eighteen (18) years of age or older any services provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency.* (7-1-11)~~

0~~5~~3. Documentation of Plan Changes. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. (7-1-11)

653. ~~*REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN AGES THREE THROUGH SEVENTEEN AND ADULTS RECEIVING IBI OR ADDITIONAL DDA SERVICES PRIOR AUTHORIZED UNDER THE EPSDT PROGRAM~~ DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of ~~*any DDA services, the DDA must determine and document the participant's eligibility in accordance with*~~ developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ~~*For eligibility determination, the following assessments must be obtained or completed by the DDA:* (7-1-11)~~( )

~~***a.*** *Medical Assessment. This must contain medical information that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or* (7-1-11)~~

~~***b.*** *Psychological Assessment. If the medical assessment does not establish categorical eligibility, the DDA must obtain or conduct a psychological assessment that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code.* (7-1-11)~~

~~***c.*** *Standardized Comprehensive Developmental Assessment. This must contain developmental information regarding functional limitations that accurately reflects the current status of the person and establishes functional eligibility based on substantial limitations in accordance with Section 66-402(5)(b), Idaho Code.* (7-1-11)~~

02. Intake. ~~*The DDA must obtain information that accurately reflects the current status and needs of the participant prior to the delivery of services.*~~ Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a plan developer or an Individual Service Plan. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. ~~(7-1-11)~~( )

~~***a.*** *The person must have been determined by the DDA to be eligible for DDA services.* (7-1-11)~~

~~***b.*** *The DDA must obtain or complete a comprehensive medical and medical/social history.* (7-1-11)~~

~~***03. Assessments.*** *Requirements for assessments are found under Subsections 655.01 through 655.06 of these rules.* (7-1-11)~~

0~~4~~3. Individual Program Plan (IPP) Definitions. The delivery of ~~*each service*~~ developmental therapy on a plan ~~*of service*~~ must be defined in terms of the type, amount, frequency, and duration of the service. ~~(7-1-11)~~( )

a. Type of service refers to the kind of service described in terms of: (7-1-11)

~~***i.*** *Discipline;* (7-1-11)~~

i~~*i*~~. Group, individual, or family; and (7-1-11)

ii~~*i*~~. Whether the service is home, community, or center-based. (7-1-11)

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-11)

c. Frequency of service is the number of times service is offered during a week or month. (7-1-11)

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-11)

0~~5~~4. Individual Program Plan (IPP). ~~*For participants three (3) through seventeen (17) years of age and for adults receiving EPDST services, the DDA is required to complete an*~~

~~IPP.~~ ~~(7-1-11)~~( )

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-11)

b. The planning process must include the participant, ~~and his parent or~~ his legal guardian if one exists, ~~if applicable,~~ and others the participant or his ~~parent or~~ legal guardian chooses. The participant~~'s parent or~~ and his legal guardian if one exists must sign the IPP indicating ~~his~~ participation in its development. The ~~parent or~~ participant and his legal guardian if one exists must be provided a copy of the completed IPP by the DDA. If the participant ~~and his parent~~ or his legal guardian ~~are~~ is unable to participate, the reason must be documented in the participant's record. A physician or other practitioner of the healing arts, ~~and the parent or~~ the participant, and his legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan~~, except as provided under Subsection 652.02.b.ii. of these rules~~. ~~(7-1-11)~~( )

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations ~~must be signed by the physician or other practitioner of the healing arts~~ require written authorization by the participant, his legal guardian if one exists, and must be maintained in the participant's file. ~~A parent or legal guardian must sign the IPP prior to initiation of any services identified within the plan.~~ ~~(7-1-11)~~( )

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-11)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-11)

i. The participant's name and medical diagnosis; (7-1-11)

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-11)

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; (7-1-11)

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-11)

v. A list of the participant's current personal goals, interests and choices; (7-1-11)

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; (7-1-11)

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-11)

viii. The ~~*discipline professional or*~~ Developmental Specialist responsible for each objective; ~~*(7-1-11)*~~( )

ix. The target date for completion of each objective; (7-1-11)

x. The review date; and (7-1-11)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include ~~*integrated classrooms,*~~ community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. ~~*(7-1-11)*~~( )

0~~6~~5. Documentation of Plan Changes. Documentation of required ~~*plan of service or*~~ Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: ~~*(7-1-11)*~~( )

a. The reason for the change; (7-1-11)

b. Documentation of coordination with other services providers, where applicable; (7-1-11)

c. The date the change was made; and (7-1-11)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant ~~*or the participant's parent or*~~ and his legal guardian~~*, if applicable*~~ if one exists. Changes in type, amount, or duration of services ~~*require written authorization from*~~ must be recommended by a physician or other practitioner of the healing arts. ~~*and*~~ Such recommendations require written authorization by the participant ~~*or the participant's parent or*~~ and his legal guardian if one exists prior to the change. If the signatures of the participant ~~*or the parent*~~ or his legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. ~~*(7-1-11)*~~( )

~~654. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN BIRTH TO THREE YEARS OF AGE (INFANT TODDLER).~~
~~Services provided by a DDA to children birth to three (3) years of age must meet the requirements~~

and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. For children birth to age three (3), the IFSP will be used in lieu of the Individual Program Plan (IPP). *(7-1-11)*

***01. Eligibility Determination**. For a child birth to three (3) years of age, prior to the delivery of any DDA services:* *(7-1-11)*

***a.** In accordance with 34 CFR 303.321(e), the Department's regional Infant Toddler Program will determine eligibility for DDA services in accordance with Section 66-402, Idaho Code.* *(7-1-11)*

***b.** Upon request from the DDA, and after receiving consent from the parent or legal guardian for release of information, the Department's regional Infant Toddler Program will provide the DDA with documentation of the child's eligibility including a copy of the current IFSP, addendum(a) to the IFSP, assessments, and service records related to current DDA services.* *(7-1-11)*

***02. Intake**. Prior to the delivery of DDA services:* *(7-1-11)*

***a.** The DDA must obtain both a copy of the current IFSP and a copy of all current assessment(s) used by the Department's regional Infant Toddler Program to determine eligibility for DDA services; and* *(7-1-11)*

***b.** The DDA must conduct a meeting with the child's family, in cooperation with the child's service coordinator, to review the current IFSP and confirm the family's resources, priorities, and concerns with regard to the child's current developmental status and therapeutic needs.* *(7-1-11)*

***03. Individualized Family Service Plan (IFSP)**. The Department or its designee will develop the initial IFSP for each eligible child, birth to three (3) years of age. Each DDA that provides DDA services to an eligible child, birth to three (3) years of age, must implement services according to the IFSP for that child as required by the Individuals with Disabilities Education Act, (P.L. 108-446, December 2004), Part C, Section 636 (d) and Title 16, Chapter 1, Idaho Code. The DDA must use the Department-approved IFSP form in accordance with 34 CFR 303.344. The procedures for IFSP development, review, and assessment must be in accordance with 34 CFR 303.342.* *(7-1-11)*

***a.** Development of the IFSP. For a child who has been evaluated for the first time and has been determined to be eligible for DDA services, the initial IFSP developed by the Department must be completed within a forty-five (45) day time period in accordance with 34 CFR 303.321(e).* *(7-1-11)*

***b.** Periodic Reviews. In cooperation with the child's service coordinator and other*

~~service providers, the DDA must participate in a review of the IFSP to be conducted every six (6) months, or more frequently, if conditions warrant or if the family requests such a review. The purpose of the periodic review is to identify progress made toward each objective and to determine whether these current outcomes and objectives need modification or revision. The review may be carried out in a meeting or by another means that is acceptable to the parent or legal guardian and other participants. These reviews must include the degree to which progress toward achieving the outcomes is being made.~~ ~~(7-1-11)~~

~~i. The DDA must provide the child's service coordinator with any current assessments and other information from the ongoing assessment of the child to determine what services are needed and will be provided.~~ ~~(7-1-11)~~

~~ii. The DDA must identify outcomes and objectives for inclusion in the IFSP for any services to be provided through the DDA.~~ ~~(7-1-11)~~

~~c. Participants in the IFSP meetings and periodic reviews must be in accordance with 34 CFR 303.343. IFSP meetings and periodic reviews must include the parent or legal guardian, the service coordinator working with the family, persons providing direct services to the child and family as appropriate, and persons directly involved in conducting the assessments of the child. The family is encouraged to invite any family member, advocate, or friend to the meeting to assist in the planning process.~~ ~~(7-1-11)~~

~~d. The IFSP or IFSP addendum must be in accordance with 34 CFR 303.344, and include the following:~~ ~~(7-1-11)~~

~~i. A statement of the outcome;~~ ~~(7-1-11)~~

~~ii. Steps to support transitions;~~ ~~(7-1-11)~~

~~iii. Behaviorally-stated objectives toward meeting that outcome;~~ ~~(7-1-11)~~

~~iv. Frequency, intensity, and method of delivering a service to meet the outcome;~~ ~~(7-1-11)~~

~~v. Measurability criteria, strategies, and activities;~~ ~~(7-1-11)~~

~~vi. Start and end dates;~~ ~~(7-1-11)~~

~~vii. A description of the natural environments in which early intervention services are appropriately provided, including a justification of the extent, if any, to which services will not be provided in a natural environment; and~~ ~~(7-1-11)~~

~~viii. A list of who will be involved in the direct intervention.~~ ~~(7-1-11)~~

~~e. There must be an order by a physician or other practitioner of the healing arts for all DDA services included on the IFSP.~~ ~~(7-1-11)~~

~~f. Transition to preschool programs must be in accordance with 34 CFR 303.148.~~

(7-1-11)

i. At the IFSP review closest to the child's second birthday, outcomes must be written to address the steps needed to ensure appropriate services for the child at age three (3). (7-1-11)

ii. At least six (6) months prior to the child's third birthday, the DDA must document contact with the child's service coordinator and participation in the transition planning process at the time of referral of the child to his local school district for IDEA, Part B, eligibility determination. (7-1-11)

04. Parental Consent and Right to Decline Service. Written parental consent must be obtained before: (7-1-11)

a. Conducting the assessment of a child; and (7-1-11)

b. Initiating the provision of services. (7-1-11)

05. Ongoing Assessment of the Child. The assessment of each child must: (7-1-11)

a. Be conducted by personnel trained to utilize appropriate methods and procedures; (7-1-11)

b. Be based on informed clinical opinion; and (7-1-11)

c. Include the following: (7-1-11)

i. A review of pertinent records related to the child's current health status and medical history. (7-1-11)

ii. An assessment of the child's level of functioning in cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development. (7-1-11)

iii. An assessment of the unique needs of the child in terms of each of the developmental areas mentioned above in Subsection 654.05.c.ii. of this rule, including the identification of services appropriate to meet those needs. (7-1-11)

06. Services in the Natural Environment. Natural environments are settings that are natural or normal for the child's age peers who have no disability. To the maximum extent appropriate, in order to meet the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. (7-1-11)

07. Documentation of Program Changes. Documentation of required plan or Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other services providers, where applicable, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If

~~*there are changes to the Program Implementation Plan that affect the IFSP, an addendum to the IFSP must be completed:* (7-1-11)~~

~~***a.*** *In cooperation with the service coordinator;* (7-1-11)~~

~~***b.*** *With consent of the parent;* (7-1-11)~~

~~***c.*** *With an order by the child's physician or other practitioner of the healing arts;* (7-1-11)~~

~~***d.*** *With all changes documented on the enrollment form; and* (7-1-11)~~

~~***e.*** *A copy of the addendum and the enrollment form must be submitted to the Department.* (7-1-11)~~

655~~4~~. ~~*DDA SERVICES*~~ DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. ~~*Psychological assessment benefits are separately limited to four (4) hours annually. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid.*~~ The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: ~~(3-29-12)~~( )

a. Comprehensive Developmental Assessment; and ~~(7-1-11)~~( )

b. ~~*Comprehensive Intensive Behavioral Intervention (IBI)*~~ Specific Skill Assessment. ~~*Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the four (4) hour limitation described in Subsection 655.01 of this rule;* (3-29-12)~~( )

~~***c.*** *Occupational Therapy Assessment;* (7-1-11)~~

~~***d.*** *Physical Therapy Assessment;* (7-1-11)~~

~~***e.*** *Speech and Language Assessment;* (7-1-11)~~

~~***f.*** *Medical/Social History; and* (7-1-11)~~

~~***g.*** *Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview.* (7-1-11)~~

02. Comprehensive Developmental Assessments ~~*Conducted by the DDA*~~. Assessments must be conducted by qualified professionals defined under Section 65~~7~~5 of these

rules ~~*for the respective discipline or areas of service*~~. ~~*(7-1-11)*~~( )

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

~~*v. For medical or psychiatric assessments, formulate a diagnosis. For psychological assessments, formulate a diagnosis and recommend the type of therapy necessary to address the participant's needs. For other types of assessments, recommend the type and amount of therapy necessary to address the participant's needs.*~~ ~~*(7-1-11)*~~

~~***b.*** *Current Assessments Required. When the DDA determines developmental disabilities eligibility, current assessments must be completed or obtained as necessary.*~~ ~~*(7-1-11)*~~

~~***e***~~**b.** Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

~~***d.*** *Assessment must be completed within forty-five (45) days.*~~ ~~*(7-1-11)*~~

~~*i. With the exception noted under Subsection 655.02.d.ii. of this rule, each assessment must be completed within forty-five (45) calendar days of the date it was recommended by the physician or other practitioner of the healing arts. If the assessment is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay.*~~ ~~*(7-1-11)*~~

~~*ii. This forty-five (45) day requirement does not apply to participant plans of service authorized under Sections 507 through 515 of these rules.*~~ ~~*(7-1-11)*~~

~~***03***~~**c.** Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. ~~*(7-1-11)*~~

~~***a.***~~ To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. ~~*(3-29-12)*~~( )

~~***b.*** *Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the participant's current status in that service area. If, during the required review of the assessment(s), the latest*~~

~~*assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so.* (3-29-12)~~

~~***c.*** *Medical/social histories and medical assessments must be completed at a frequency determined by the recommendation of a professional qualified to conduct those assessments.* (3-29-12)~~

~~***d.*** *Once initial eligibility has been established, annual assessment of IQ is not required for persons whose categorical eligibility for DDA services is based on a diagnosis of mental retardation. IQ testing must be reconducted on a frequency determined and documented by the agency psychologist or at the request of the Department.* (3-29-12)~~

~~***e.*** *Assessments must be completed or obtained prior to the delivery of therapy in each type of service.* (3-29-12)~~

~~***f.*** *A current psychological assessment must be updated in accordance with Subsection 655.03.f. of these rules:* (3-29-12)~~

~~*i.* *Prior to the initiation of restrictive interventions to modify inappropriate behavior(s);* (7-1-11)~~

~~*ii.* *When it is necessary to determine eligibility for services or establish a diagnosis;* (7-1-11)~~

~~*iii.* *When a participant has been diagnosed with mental illness; or* (7-1-11)~~

~~*iv.* *When a child has been identified to have a severe emotional disturbance.* (7-1-11)~~

~~***04. Assessments for Adults****. DDAs must obtain assessments required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 of these rules. All specific skill assessments must be conducted in accordance with Subsection 655.06 of these rules.* (7-1-11)~~

~~***05. Types of Comprehensive Assessments****.* (7-1-11)~~

~~***a***~~**d.** Comprehensive Developmental Assessment. A comprehensive developmental assessment must ~~*be conducted by a qualified Development Specialist and*~~ reflect a person's developmental status in the following areas: ~~(7-1-11)~~( )

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

~~***b.*** *Comprehensive Intensive Behavioral Intervention (IBI) Assessment. The requirements for the comprehensive IBI assessment are found under Subsection 656.03 of these rules.* (7-1-11)~~

~~***c.*** *Occupational Therapy Assessment. Occupational therapy assessments must be conducted by an occupational therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs.* (7-1-11)~~

~~***d.*** *Physical Therapy Assessment. Physical therapy assessments must be conducted by a physical therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs.* (7-1-11)~~

~~***e.*** *Speech and Language Assessment. Speech and language assessments must be conducted by a Speech-Language Pathologist who is qualified under Section 657 of these rules.* (7-1-11)~~

~~***f.*** *Medical Assessments. Medical assessments must be completed by a physician or other practitioner of the healing arts who is qualified in accordance with Section 657 of these rules and accurately reflects the current status and needs of the person.* (7-1-11)~~

~~***g.*** *Medical/Social History. Medical/social histories must be completed by a licensed social worker or other qualified professional working within the scope of his license. The medical/social history is a narrative report that must include:* (7-1-11)~~

~~*i. Medical history including age of onset of disability, prenatal and postnatal birth issues, other major medical issues, surgeries, and general current health information;* (7-1-11)~~

~~*ii. Developmental history including developmental milestones and developmental treatment interventions;* (7-1-11)~~

~~*iii. Personal history including social functioning/social relationships, recreational activities, hobbies, any legal and criminal history, and any history of abuse;* (7-1-11)~~

~~*iv. Family history including information about living or deceased parents and siblings, family medical history, relevant family cultural background, resources in the family for the participant;* (7-1-11)~~

~~*v. Educational history including any participation in special education;* (7-1-11)~~

~~*vi. Prevocational or vocational paid and unpaid work experiences;* (7-1-11)~~

~~*vii. Financial resources; and* (7-1-11)~~

~~*viii. Recommendation of services necessary to address the participant's needs.* *(7-1-11)*~~

~~***h.*** *Hearing Assessment. A hearing assessment must be conducted by an audiologist who is qualified under Section 657 of these rules.* *(7-1-11)*~~

~~***i.*** *Psychological Assessment. A psychological assessment includes psychological testing for diagnosis and assessment of personality, psychopathology, emotionality, or intellectual abilities (IQ test). The assessment must include a narrative report. Psychological assessment encompasses psychological testing and the psychiatric diagnostic interview.* *(7-1-11)*~~

~~***j.*** *Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of a person's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses, or functional impairments.* *(7-1-11)*~~

~~*i. Psychological testing may be provided when in direct response to a specific assessment question.* *(7-1-11)*~~

~~*ii. The psychological report must contain the reason for the performance of this service.* *(7-1-11)*~~

~~*iii. Agency staff may deliver this service if they meet one (1) of the following qualifications:* *(7-1-11)*~~

~~*(1) Licensed Psychologist;* *(7-1-11)*~~

~~*(2) Psychologist Extender; or* *(7-1-11)*~~

~~*(3) A qualified therapist listed in Subsection 651.03.e. of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing.* *(7-1-11)*~~

~~***k.*** *Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must be conducted in accordance with Subsection 651.09 of these rules.* *(7-1-11)*~~

0~~6~~3. ~~*Requirements for***~~ Specific Skill Assessments**. Specific skill assessments must: ~~*(7-1-11)*~~( )

a. ~~*Further Assessment.*~~ Further assess an area of limitation or deficit identified on a comprehensive assessment. ~~*(7-1-11)*~~( )

b. ~~*Related to a Goal.*~~ Be related to a goal on the IPP~~,~~ or ISP~~, or IFSP~~. ~~*(7-1-11)*~~( )

c. ~~*Conducted by Qualified Professionals.*~~ Be conducted by qualified professionals ~~*for the respective disciplines as defined in this chapter*~~. ~~*(7-1-11)*~~( )

d. ~~*Determine a Participant's Skill Level.*~~ Be conducted for the purposes of determining a participant's skill level within a specific domain. ~~*(7-1-11)*~~( )

e. ~~*Determine Baselines.*~~ Be used to determine baselines and develop the program implementation plan. ~~*(7-1-11)*~~( )

0~~7~~4. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. ~~*When a participant receives developmental therapy, d*~~Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. ~~*(7-1-11)*~~( )

b. ~~*Additional Requirements for Participants Eighteen Years or Older. For participant's eighteen (18) years of age or older,*~~ DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. ~~*(7-1-11)*~~( )

~~***c.*** *Additional Requirements for Participants Seven Through Sixteen. For participants ages seven (7) through sixteen (16), the DDA must also document that the child has been referred to the local school district in accordance with the collaboration requirements in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."* *(7-1-11)*~~

~~***d.*** *Additional Requirements for Participants Birth to Three Years of Age. For participants birth to age three (3), the following are required in addition to those requirements in Subsection 654.01 of these rules:* *(7-1-11)*~~

~~*i. Documentation of the six (6) month and annual reviews;* *(7-1-11)*~~

~~*ii. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to ensure service continuity and access to community services as early intervention services end at age three (3);* *(7-1-11)*~~

~~*iii. Documentation that participant rights have been met in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."* (7-1-11)~~

~~*iv. Documentation of participation in the transition meeting with the school district; and* (7-1-11)~~

~~*v. Documentation of consultation with other service providers who are identified on the IFSP.* (7-1-11)~~

0~~8~~5. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements: (7-1-11)

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

~~656. REQUIREMENTS FOR THE DELIVERY OF INTENSIVE BEHAVIORAL INTERVENTION (IBI).~~

~~**01. Individualized and Comprehensive Interventions**. IBI consists of individualized, comprehensive interventions that have been shown to be effective and are used on a short term, one-to-one basis. These interventions: (7-1-11)~~

~~**a.** Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills; or (7-1-11)~~

~~**b.** Broaden an otherwise severely restricted range of interest; and (7-1-11)~~

~~**c.** Increase the child's ability to participate in other therapies and environments. (7-1-11)~~

~~**02. IBI Authorization and Review**. IBI services must be reviewed and prior authorized for each service year as follows: (7-1-11)~~

~~**a.** Initial IBI Authorization. The Department determines IBI eligibility based on information submitted by the DDA and other information gathered by the Department as deemed necessary. At least twenty (20) working days prior to the intended start date of IBI services, the DDA must use Department-approved forms to submit; (7-1-11)~~

~~i. Evidence of the child's eligibility for Intensive Behavioral Intervention; (7-1-11)~~

~~ii. The comprehensive IBI assessments; (7-1-11)~~

~~iii. The Program Implementation Plans; (7-1-11)~~

~~iv. The number of hours of service requested; and (7-1-11)~~

~~v. Measurable objectives. (7-1-11)~~

~~**b.** Three- (3) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. (7-1-11)~~

~~**c.** Six- (6) Month Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit: (7-1-11)~~

~~i. The three- (3) month review; (7-1-11)~~

~~ii. Documentation of the child's progress on IBI goals and outcomes of the IBI objectives for those six (6) months; and (7-1-11)~~

~~iii. When continuing IBI services are requested, the Program Implementation Plans, the number of hours of service requested, and the measurable objectives, using Department-approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services. (7-1-11)~~

~~**d.** Nine- (9) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. (7-1-11)~~

~~***c.*** *Annual Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit:* *(7-1-11)*~~

~~*i. The nine- (9) month review;* *(7-1-11)*~~

~~*ii. Documentation of the child's progress on IBI goals and outcomes of the IBI objectives for that year; and* *(7-1-11)*~~

~~*iii. When continuing IBI services are requested:* *(7-1-11)*~~

~~*(1) A new SIB-R that reflects the child's current status and any additional information required to establish continuing eligibility;* *(7-1-11)*~~

~~*(2) The Program Implementation Plans; and* *(7-1-11)*~~

~~*(3) The number of hours of service requested and the measurable objectives, using Department-approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services.* *(7-1-11)*~~

~~***03. Comprehensive IBI Assessment****. A comprehensive IBI assessment must be completed by a certified IBI professional prior to the initial provision of IBI or IBI Consultation. The results of the assessment must form the basis for planning interventions. The assessment must include the following:* *(7-1-11)*~~

~~***a.*** *Review of Assessments and Relevant Histories.* *(7-1-11)*~~

~~*i. Medical history, medications, and current medical status;* *(7-1-11)*~~

~~*ii. Medical/social history that includes a developmental history and onset of developmental disability;* *(7-1-11)*~~

~~*iii. Comprehensive developmental assessment reflecting the child's current status;* *(7-1-11)*~~

~~*iv. Specific skill assessment, when such an assessment is completed;* *(7-1-11)*~~

~~*v. SIB-R Maladaptive Index and a list of the child's maladaptive behaviors;* *(7-1-11)*~~

~~*vi. Baseline of the child's maladaptive behavior(s), if available;* *(7-1-11)*~~

~~*vii. Psychological assessments and results of psychometric testing, or for very young children, a developmental assessment with equivalent age-appropriate social-emotional status, if available;* *(7-1-11)*~~

~~*viii. A mental health or social and emotional assessment, such as the Child and Adolescent Functional Assessment Scale (CAFAS), when one has been completed;* *(7-1-11)*~~

~~*ix. Public school or Infant Toddler Program records including relevant birth records, multidisciplinary team assessments, recommendations, and Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs); and* (7-1-11)~~

~~*x. Other relevant assessments that may be available, including those for speech and hearing and physical and occupational therapy.* (7-1-11)~~

~~***b.** Interviews. Interviews must be conducted with the child, if possible, and to the extent of the child's abilities; the child's parent or legal guardian, or the primary care provider; and any other individuals who spend significant amounts of time with the child. These interviews must result in a written summary of the findings of each interview and include the following:* (7-1-11)~~

~~*i. Description of the child's desired and problem behaviors;* (7-1-11)~~

~~*ii. Opinion about environmental stimuli that appear to precede problem behaviors;* (7-1-11)~~

~~*iii. Opinion about the internal states or setting events that precede desired and problem behaviors;* (7-1-11)~~

~~*iv. Opinion about identification of stimuli that maintain the desired or problem behaviors; and* (7-1-11)~~

~~*v. Opinion about factors that alleviate problem behaviors and increase desired behaviors.* (7-1-11)~~

~~***c.** Observation of the Child. Observations of the child must occur in environments in which the child spends significant amounts of time and where problem behaviors have been reported. Results of the observations must include the following:* (7-1-11)~~

~~*i. Specific descriptions and frequencies of problem behaviors;* (7-1-11)~~

~~*ii. Identification of environmental stimuli that appear to precede problem behaviors;* (7-1-11)~~

~~*iii. Identification of internal states or setting events that appear to precede problem behaviors;* (7-1-11)~~

~~*iv. Identification of stimuli that maintain the desired or problem behaviors; and* (7-1-11)~~

~~*v. Identification of factors that alleviate problem behaviors and increase desired behaviors.* (7-1-11)~~

~~***d.** Clinical Opinion. Clinical opinion about the underlying causes, antecedents, motivations, and communicative intent of desired and problem behaviors.* (7-1-11)~~

~~***04. IBI Program Implementation Plans Requirements****. In addition to the requirements under Subsections 655.08.a. through 655.08.g. of these rules, the following are also required for IBI Implementation Plans:* *(7-1-11)***~~

~~***a.*** *All IBI Implementation Plans must be completed on the Department approved form.* *(7-1-11)***~~

~~***b.*** *On all IBI Implementation Plan cover sheets, the signature of a parent or legal guardian is required. If the signatures of the parent or legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained.* *(7-1-11)***~~

~~***05. IBI Transition Plan****. An IBI transition plan must be developed when it is anticipated that IBI services will be terminated within the next Department or agency review period and the child will be moving into natural learning environments or less intensive therapy settings. The IBI transition plan may not be used as a substitute for, nor does it replace the transition plans required under Sections 653 and 654 of these rules. IBI transition plans must include the following steps to support the transition and the timelines for those steps:* *(7-1-11)***~~

~~***a.*** *Setting. The setting to which the child will be moving and the therapists or persons who will be interacting with the child; and* *(7-1-11)***~~

~~***b.*** *Training of New Therapists or Other Persons. How behavioral intervention techniques will be shared with new therapists or other persons in the new environments to encourage generalization and maintenance of appropriate behavior and action to be taken if the child demonstrates regression in the new setting in skills learned through IBI.* *(7-1-11)***~~

~~***06. IBI Consultation****. Professionals may provide IBI consultation to parents and other family members, professionals, paraprofessionals, school personnel, child care providers, or other caregivers who provide therapy or care for an IBI eligible child in other disciplines to ensure successful integration and transition from IBI to other therapies, services, or types of care. IBI consultation objectives and methods of measurement must be developed in collaboration with the person receiving IBI consultation.* *(7-1-11)***~~

~~***a.*** *Service Delivery Qualification. IBI consultation must be delivered by an IBI professional who meets the requirements in Section 657 of these rules.* *(7-1-11)***~~

~~***b.*** *Measurable Progress. IBI consultation must result in measurable improvement in the child's behavior. It is not intended to be used for educational purposes only.* *(7-1-11)***~~

~~***c.*** *Evidence of Progress. Persons who receive IBI consultation must meet with the IBI professional, agree to follow an IBI Implementation Plan, and provide evidence of progress.* *(7-1-11)***~~

~~***d.*** *Individualized. IBI consultation may not be reimbursed when it is delivered to a group of parents. IBI consultation is specific to the unique circumstances of each child.* *(7-1-11)***~~

65~~7~~5. ~~*DDA SERVICES*~~ DEVELOPMENTAL THERAPY: ~~*DDA*~~ PROVIDER QUALIFICATIONS AND DUTIES.

~~***01. Audiologist, Licensed**. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification.* (7-1-11)~~

~~***02. Counselor, Licensed Clinical Professional**. A person licensed to practice as a clinical professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists."* (7-1-11)~~

~~***03. Counselor, Licensed Professional**. A person licensed to practice as a professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists."* (7-1-11)~~

~~***04. Marriage and Family Therapist**.* (7-1-11)~~

~~***a.** Licensed Marriage and Family Therapist. A person licensed to practice as a marriage and family therapist in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists."* (7-1-11)~~

~~***b.** Registered Marriage and Family Therapist Intern. A person registered to practice as a marriage and family therapist intern under the direct supervision of a Licensed Marriage and Family Therapist, in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists."* (7-1-11)~~

0~~5~~1. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

~~***06. Developmental Specialist for Children Three Through Seventeen**. A Developmental Specialist providing developmental assessment and therapy services to children ages three (3) through seventeen (17) must meet the requirements for a Developmental Specialist for adults, and must also meet the following requirements:* *(7-1-11)*~~

~~***a.** Successfully complete a competency course approved by the Department that relates to developmental assessment and therapy for children; and* *(7-1-11)*~~

~~***b.** Pass a competency examination approved by the Department.* *(7-1-11)*~~

~~***07. Developmental Therapy Paraprofessionals Delivering Services to Participants Age Three and Older**. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children age (3) and older if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age.* *(7-1-11)*~~

~~***08. Developmental Specialist for Children Birth to Three**.* *(7-1-11)*~~

~~***a.** To provide developmental assessments and therapy to children birth to three (3) years of age, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following:* *(7-1-11)*~~

~~*i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or* *(7-1-11)*~~

~~*ii. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate;* *(7-1-11)*~~

~~*iii. A bachelor's or masters degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:* *(7-1-11)*~~

~~*(1) Promotion of development and learning for children from birth to three (3) years;* *(7-1-11)*~~

~~*(2) Assessment and observation methods for developmentally appropriate assessment*~~

~~*of young children;* (7-1-11)~~

~~*(3) Building family and community relationships to support early interventions;* (7-1-11)~~

~~*(4) Development of appropriate curriculum for young children, including IFSP and IEP development;* (7-1-11)~~

~~*(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and* (7-1-11)~~

~~*(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.* (7-1-11)~~

~~***b.** Electives closely related to the content under Subsection 657.08.a.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education.* (7-1-11)~~

~~***c.** A developmental specialist who possesses a bachelor's or master's degree listed above under Subsection 657.08.a.ii. of this rule, must have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with his approved, conditional hiring agreement.* (7-1-11)~~

~~***d.** When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area:* (7-1-11)~~

~~*i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired.* (7-1-11)~~

~~*ii. Satisfactory progress will be determined on an annual review by the Department.* (7-1-11)~~

~~*iii. An individual who has an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as he demonstrates satisfactory progress on the plan and complete the requirements on the plan within three (3) years of his date of hire.* (7-1-11)~~

~~***09. Developmental Therapy Paraprofessionals Delivering Services to Children Birth to Three**. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children birth to three (3) years of age if they are under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. Developmental therapy paraprofessionals serving infants and toddlers from birth to*~~

~~three (3) years of age must meet the following qualifications:~~ ~~(7-1-11)~~

~~**a.** Be at least eighteen (18) years of age;~~ ~~(7-1-11)~~

~~**b.** Be a high school graduate or have a GED; and~~ ~~(7-1-11)~~

~~**c.** Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education or closely-related coursework; or~~ ~~(7-1-11)~~

~~**d.** Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.~~ ~~(7-1-11)~~

~~**10. Intensive Behavioral Intervention (IBI) Professional Delivering Services to Participants Three to Twenty One**. A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements:~~ ~~(7-1-11)~~

~~**a.** Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college.~~ ~~(7-1-11)~~

~~**b.** Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context.~~ ~~(7-1-11)~~

~~**c.** Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410.~~ ~~(7-1-11)~~

~~**11. IBI Paraprofessionals Delivering Services to Participants Three to Twenty One**. A certified IBI paraprofessional may be used to provide IBI under the supervision of a certified IBI professional and must comply with Section 658 of these rules. An IBI paraprofessional must also:~~ ~~(7-1-11)~~

~~**a.** Be at least eighteen (18) years of age;~~ ~~(7-1-11)~~

~~**b.** Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year of supervised experience working with children with developmental disabilities. The year of experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context.~~ ~~(7-1-11)~~

~~**c.** Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410. (7-1-11)~~

~~**12. IBI Professionals Delivering Services to Children Birth to Three**. A person qualified to provide or direct the provision of IBI to children under three (3) years of age must meet the staff qualifications described under Subsections 657.08.a.ii. through 657.08.d. of these rules, 657.10.b. and 657.10.c. of these rules and the certification and training requirements above under Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)~~

~~**13. IBI Paraprofessionals Delivering Services to Children Birth to Three**. A paraprofessional serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)~~

~~**a.** Be at least eighteen (18) years of age; (7-1-11)~~

~~**b.** Be a high school graduate or have a GED; and (7-1-11)~~

~~**c.** Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) credits in child development, special education, or closely-related coursework; or (7-1-11)~~

~~**d.** Have three (3) years of documented experience providing care to infants, toddlers or children under five (5) years of age under the supervision of a child development professional, certified educator, or licensed therapist or Developmental Specialist. (7-1-11)~~

~~**e.** Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410, and Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)~~

~~**14. Nurse Practitioner**. A licensed professional nurse (RN) who has met all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-11)~~

~~**15. Occupational Therapist**. A person qualified to conduct occupational therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (7-1-11)~~

~~**16. Physical Therapist**. A person qualified to conduct physical therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.05, "Licensure of Physical Therapists Idaho State Board of Medicine and Physical Therapist Assistants." (7-1-11)~~

~~**17. Physician**. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code. (7-1-11)~~

~~**18. Physician Assistant**. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-11)~~

~~***a.*** *Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or* *(7-1-11)*~~

~~***b.*** *Has satisfactorily completed a program for preparing physician's assistants that:* *(7-1-11)*~~

~~*i. Was at least one (1) academic year in length; and* *(7-1-11)*~~

~~*ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and* *(7-1-11)*~~

~~*iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.* *(7-1-11)*~~

~~***19. Psychiatric Nurse, Certified****. A licensed professional nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree.* *(7-1-11)*~~

~~***20. Psychiatrist****. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code, and who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.* *(7-1-11)*~~

~~***21. Psychologist****. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners."* *(7-1-11)*~~

~~***22. Psychologist Extender****. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses.* *(7-1-11)*~~

~~***23. Social Worker, Licensed****. A person licensed in accordance with the Social Work Licensing Act, Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners."* *(7-1-11)*~~

~~***24. Masters Social Worker, Licensed****. A person who is licensed as a masters social worker (LMSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners."* *(7-1-11)*~~

~~***25. Clinical Social Worker, Licensed****. A person who is licensed as a clinical social worker (LCSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners."* *(7-1-11)*~~

~~***26. Speech-Language Pathologist, Licensed****. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice*

~~*Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification.* (7-1-11)~~

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. ( )

~~27~~03. Requirements for Collaboration with Other Providers. (7-1-12)T

a. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the Psychosocial Rehabilitation (PSR) plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (7-1-12)T

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. (7-1-12)T

65~~8~~6. GENERAL STAFFING REQUIREMENTS ~~*FOR AGENCIES*~~.

01. Standards for Paraprofessionals Providing Developmental Therapy ~~*and IBI*~~. When a paraprofessional provides ~~*either*~~ developmental therapy ~~*or IBI*~~, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 65~~7~~5 of these rules. A ~~*paraprofessional providing IBI must be supervised by an IBI professional; a*~~ paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. ~~*Paraprofessionals providing developmental therapy to children birth to three (3) years of age must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group.*~~ For paraprofessionals to provide developmental therapy ~~*or IBI*~~ in a DDA, the agency must adhere to the following standards: ~~*(7-1-11)*~~( )

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service~~,~~ or develop a Program Implementation Plan~~, or conduct IBI consultation~~. These activities must be conducted by a professional qualified to provide the service. ~~*(3-29-12)*~~( )

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or

more often if necessary: (7-1-11)

i. Give instructions; (7-1-11)

ii. Review progress; and (7-1-11)

iii. Provide training on the program(s) and procedures to be followed. (7-1-11)

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-11)

~~***d.*** *Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI.* (7-1-11)~~

~~***e.*** *Additional Training Requirements for IBI Professionals and IBI Paraprofessionals. Qualified IBI professionals and IBI paraprofessionals must complete and pass a Department-approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of IBI and ethical standards. Specifically, the curriculum must include:* (7-1-11)~~

~~*i. Assessment of individuals;* (7-1-11)~~

~~*ii. Behavioral management;* (7-1-11)~~

~~*iii. Services or treatment of individuals;* (7-1-11)~~

~~*iv. Supervised practical experience; and* (7-1-11)~~

~~*v. Successful completion of a student project that includes an observation of demonstrated competencies for all individuals applying for initial certification or recertification after July 1, 2003.* (7-1-11)~~

~~***f.*** *Continuing Training Requirements for IBI Professionals and IBI Paraprofessionals. Each IBI professional and IBI paraprofessional, in order to maintain certification, must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.* (7-1-11)~~

~~*i. The initial IBI certification training meets the yearly training requirement for the calendar year in which the IBI professional or paraprofessional was first certified.* (7-1-11)~~

~~*ii. If the individual has not completed the required training during any yearly training period, he may not provide IBI services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training*~~

~~hours accumulate, they will be accounted first to any training deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period.~~ ~~(7-1-11)~~

~~iii. An individual may remain IBI certified, despite being unable to bill for services, through two (2) consecutive annual training periods during which that individual has deficient training hours. A DDA may begin billing for the certified IBI Professional or Paraprofessional again after the required training hours are accumulated.~~ ~~(7-1-11)~~

~~iv. If an individual completes three (3) consecutive annual training periods without having accumulated sufficient training to satisfy the training requirement for the first of those periods, that individual's IBI certification is automatically rescinded and will no longer be recognized. To be recertified, the individual must retake the state IBI exam and complete the IBI Student Project, if not previously completed.~~ ~~(7-1-11)~~

02. General Staffing Requirements for Agencies. ~~(7-1-11)~~

~~**a.** Administrative Staffing.~~ Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ~~(7-1-11)~~( )

~~i~~**a.** When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-11)

~~ii~~**b.** The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (7-1-11)

~~**b.** Other required staffing. The agency must have available, at a minimum, the following personnel, qualified in accordance with Section 657 of these rules, as employees of the agency or through formal written agreement:~~ ~~(7-1-11)~~

~~i. Speech-language pathologist or audiologist;~~ ~~(7-1-11)~~

~~ii. Developmental Specialist;~~ ~~(7-1-11)~~

~~iii. Occupational therapist;~~ ~~(7-1-11)~~

~~iv. Physical therapist;~~ ~~(7-1-11)~~

~~v. Psychologist; and~~ ~~(7-1-11)~~

~~vi. Social worker, or other professional qualified to provide the required services under the scope of his license.~~ ~~(7-1-11)~~

65~~9~~7. ~~*DDA SERVICES*~~ DEVELOPMENTAL THERAPY: PROVIDER REIMBURSEMENT.
~~*For physician services where mid-levels are authorized to administer developmental disability services, the Department reimburses based on the Department's Medical Assistance fee schedule.*~~ Payment for developmental therapy provided by a DDA must be in accordance with rates established by the Department. ~~*(3-21-12)*~~( )

658. -- 659. (RESERVED)

CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION (Sections 660 through 669)

660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
In accordance with 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ~~*(7-1-11)*~~( )

660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
In accordance with 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ~~*(7-1-11)*~~( )

661. CHILDREN'S HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of these rules, the definitions in Section 521 of these rules apply. Additionally, the following terms apply to the Children's Home and Community Based Services State Plan Option: (7-1-11)

01. Agency. A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

02. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-11)

03. Clinical Supervisor. For the purposes of these rules, the clinical supervisor is ~~T~~the professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," or is the professional responsible for the child's IFSP as designated by the Infant Toddler Program. ~~(7-1-11)~~( )

04. Community. Natural, integrated environments outside of the home, school, or DDA center-based settings. (7-1-11)

05. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (7-1-11)

a. A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-11)

b. Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; (7-1-11)

c. A business entity, open for business to the general public; and (7-1-11)

d. Primarily organized and operated to provide home and community based services and the corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. (7-1-11)

06. Home and Community Based Services State (HCBS) Plan Option. The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. (7-1-11)

07. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (7-1-11)

08. Infant Toddler Program. The Infant Toddler Program serves children birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. ( )

0~~8~~9. Integration. The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-11)

0910**. Paraprofessional**. A person qualified to provide direct support services which include respite and habilitative supports. (7-1-11)

1~~0~~1**. Professional**. A person qualified to provide direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. (7-1-11)

1~~1~~2**. Support Services**. Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. (7-1-11)

662. CHILDREN'S HCBS STATE PLAN OPTION: PARTICIPANT ELIGIBILITY. Children's Home and Community Based State Plan Option eligibility will be determined by the Department as described in Section 520 of these rules. HCBS state plan option participants must meet the following requirements: (7-1-11)

01. Age of Participants. Participants eligible to receive children's HCBS must be birth through seventeen (17) years of age. (7-1-11)

02. Eligibility Determinations. The Department must determine that prior to receiving children's HCBS state plan option services, an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, and have a demonstrated need for Children's HCBS state plan option services. (7-1-11)

03. Financial Eligibility. The Department must determine that prior to receiving children's HCBS state plan option services, the individual is in an eligibility group covered under the Title XIX Medicaid State plan, and ~~*meets one (1) of the following criteria:*~~ ~~*(7-1-11)*~~

~~***a.***~~ ~~*H*~~has an income that does not exceed one hundred fifty percent (150%) of the Federal Poverty Level (FPL)~~*;*~~. ~~*or*~~ ~~*(7-1-11)*~~( )

~~***b.*** *Has an income that does not exceed three hundred percent (300%) of the Supplemental Security Income (SSI) Federal benefit rate (FBR), and is eligible for, but does not have to be enrolled in, HCBS under a 1915(c), (d), or (e) waiver, or 1115 demonstration program.* *(7-1-11)*~~

(BREAK IN CONTINUITY OF SECTIONS)

664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. General Requirements for Program Documentation. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: (7-1-11)

a. Direct service provider information that includes written documentation of the service provided during each visit made to the participant, and contains, at a minimum, the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Intervention and support services provided during the visit; and (7-1-11)

iii. A statement of the participant's response to the service; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-11)

02. Habilitative Supports Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: (7-1-11)

a. On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. (7-1-11)

b. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. (7-1-11)

03. Family Education Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA or Infant Toddler Program must survey the parent or legal guardian's satisfaction of the service immediately following a family education session.
~~(7-1-11)~~( )

04. Reporting Requirements. The clinical supervisor must complete at a minimum, six- (6) month and annual provider status reviews for habilitative support services provided. These provider status reviews must be completed more frequently, when so required on the plan of service. (7-1-11)

a. Documentation of the six- (6) month and annual reviews must be submitted to the plan monitor. (7-1-11)

b. The provider must use Department-approved forms for provider status reviews. (7-1-11)

665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-11)

01. Respite. Respite services may be provided by an agency that is certified as a DDA and is capable of supervising the direct services provided, ~~or~~ by an independent respite provider, or by the Infant Toddler Program. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: ~~(7-1-11)~~( )

a. Must be at least sixteen (16) years of age when employed by a DDA or Infant Toddler Program; or ~~(7-1-11)~~( )

b. Must be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (7-1-11)

c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian; and (7-1-11)

d. Have received instructions in the needs of the participant who will be provided the service; and (7-1-11)

e. Demonstrate the ability to provide services according to a plan of service; and (7-1-11)

f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"; and (7-1-11)

g. When employed by a DDA or Infant Toddler Program, must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. ~~(7-1-11)~~( )

02. Habilitative Support Staff. Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative supports must meet the following minimum qualifications: ~~(7-1-11)~~( )

a. Must be at least eighteen (18) years of age; (7-1-11)

b. Must be a high school graduate or have a GED; (7-1-11)

c. Have received instructions in the needs of the participant who will be provided the service; (7-1-11)

d. Demonstrate the ability to provide services according to a plan of service; (7-1-11)

e. Must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (7-1-11)

i. Have previous work experience gained through paid employment, university practicum experience, or internship; or (7-1-11)

ii. Have on-the-job supervised experience gained through employment at a DDA or the Infant Toddler Program with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months while delivering services. ~~(7-1-11)~~( )

f. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. (7-1-11)

g. In addition to the habilitative support qualifications listed in Subsections 665.02.a. through f. of this rule, habilitative support staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

i. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or (7-1-11)

ii. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. (7-1-11)

03. Family Education. Family education must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of family education must meet the following minimum qualifications: ~~(7-1-11)~~( )

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college, and has: (7-1-11)

i. One (1) year experience providing care to children with developmental disabilities; (7-1-11)

ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; or (7-1-11)

b. Individuals working as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionist professionals prior to July 1, 2011, are qualified to provide family education until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain his certification. (7-1-11)

c. Each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide family education services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

04. Family Education for Children Birth to Three. In addition to the family education qualifications listed in Subsections 665.03.a. through 665.03.c. of this rule, family education staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master’s degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for

early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 665.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Requirements for Clinical Supervision. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in Section 685 of these rules. Clinical supervisor(s) are professionals employed by a DDA or the Infant Toddler Program on a continuous and regularly scheduled basis. ~~(7-1-11)~~( )

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA and the Infant Toddler Program must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ~~(7-1-11)~~( )

06. Requirements for Collaboration. Providers of home and community based services must coordinate with the family-centered planning team as specified on the plan of service. (7-1-11)

07. Requirements for Quality Assurance. Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. (7-1-11)

08. DDA Services. In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

680. CHILDREN'S WAIVER SERVICES.

01. Purpose of and Eligibility for Waiver Services. Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. ~~(7-1-11)~~( )

02. Waiver Services Provided by a DDA or the Infant Toddler Program. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ( )

(BREAK IN CONTINUITY OF SECTIONS)

684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All children's waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. (7-1-11)

02. General Requirements for Program Documentation. Children's waiver providers must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant the following program documentation is required: (7-1-11)

a. Direct service provider information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Services provided during the visit; and (7-1-11)

iii. A statement of the participant's response to the service, including any changes in the participant's condition; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

b. A copy of the above information will be maintained by the independent provider, Infant Toddler Program, or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ~~(7-1-11)~~( )

03. Program Implementation Plan Requirements. For each participant receiving intervention and family training services, the DDA or the Infant Toddler Program must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. ~~(7-1-11)~~( )

a. All program implementation plan objectives must be related to a goal on the participant's plan of service. (7-1-11)

b. The program implementation plan must be written, implemented, and submitted to the plan developer within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the program implementation plan is not completed within this time frame, the participant's records must contain documented participant-based ~~*documentation justifying*~~ justification for the delay. ~~(7-1-11)~~( )

c. The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11)

i. The participant's name. (7-1-11)

ii. A baseline statement. (7-1-11)

iii. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

iv. Written instructions to the staff that may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

v. Identification of the type of environment(s) and specific location(s) where services will be provided. (7-1-11)

vi. A description of the evidence-based treatment approach used for the service provided. (7-1-11)

vii. When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan. (7-1-11)

viii. When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan. (7-1-11)

ix. Target date for completion, not to exceed one (1) year. (7-1-11)

x. The program implementation plan must be reviewed and approved by the ~~*DDA*~~ clinical supervisor, as indicated by signature, credential, and date on the plan. ~~*(7-1-11)*~~( )

04. Reporting Requirements. The clinical supervisor must complete, at a minimum, six- (6) month and annual provider status reviews for habilitative intervention and family training services provided. These provider status reviews must be completed more frequently when so required on the plan of service. (7-1-11)

a. Documentation of the six (6) month and annual reviews must be submitted to the plan developer. (7-1-11)

b. The provider must use Department-approved forms for provider status reviews. (7-1-11)

05. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition, as defined by the family-centered planning team, are noted during service delivery. Such notification will be documented in the service record. (7-1-11)

06. Records Maintenance. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years

following the date of service. (7-1-11)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative intervention must meet the following minimum qualifications: ~~(7-1-11)~~( )

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; (7-1-11)

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30,

2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester

credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities ~~*Services*~~ Agencies (DDA)," ~~*or*~~ by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of therapeutic consultation must meet the following minimum qualifications: ~~*(7-1-11)*~~( )

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

d. Therapeutic consultation providers employed by a DDA or the Infant Toddler Program must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. ~~*(7-1-11)*~~( )

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities

Services (DDA)," ~~or~~ by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of crisis intervention must meet the following minimum qualifications: ~~(7-1-11)~~( )

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.04 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DD~~A~~ services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA or the Infant Toddler Program on a continuous and regularly scheduled basis. ~~(7-1-11)~~( )

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA and the Infant Toddler Program must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ~~(7-1-11)~~( )

09. Requirements for Collaboration with Other Providers. (7-1-12)T

a. Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided ~~in the DDA~~ accommodate the participant's

mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ~~*(7-1-11)*~~( )

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. (7-1-12)T

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. (5-8-09)

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (5-8-09)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences. or appears to influence the direction of a participant to other services for financial gain. (5-8-09)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

a. Hospitalization; (3-19-07)

b. Loss of housing; (3-19-07)

c. Loss of employment or major source of income; (3-19-07)

d. Incarceration; or (3-19-07)

e. Physical harm to self or others, including family altercation or psychiatric relapse. (3-19-07)

05. High Cost Services. As used in Subsection 725.01 of these rules, high cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include: (3-19-07)

a. Emergency room visits or procedures; (3-19-07)

b. Inpatient medical and psychiatric services; (3-19-07)

c. Nursing home admission and treatment; (3-19-07)

d. Institutional care in jail or prison; (3-19-07)

e. State, local, or county hospital treatment for acute or chronic illness; and (3-19-07)

f. Outpatient hospital services. (3-19-07)

06. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (5-8-09)

~~***07. Idaho Infant Toddler Program**. The Department's program that provides early intervention services to eligible infants and toddlers, from birth through thirty-six (36) months.*~~ ~~*(5-8-09)*~~

0~~8~~7. Paraprofessional. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (5-8-09)

0~~9~~8. Person-Centered Planning. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (5-8-09)

~~1~~09. Practitioner of the Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)

1~~1~~0. Service Coordination. Service coordination is a case management activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (5-8-09)

1~~2~~1. Service Coordination Plan. The service coordination plan, also known in these rules as the "plan," includes two components: (5-8-09)

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (5-8-09)

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (5-8-09)

1~~3~~2. Service Coordination Plan Development. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (5-8-09)

1~~4~~3. Service Coordinator. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (5-8-09)

1~~5~~4. Supports. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.
To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.0~~6~~5 ~~*or the requirements in Subsection 726.07 of this rule*~~. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination must be made by the Department prior to the initiation of initial and ongoing plan development and services. ~~*(5-8-09)*~~( )

01. Age. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (5-8-09)

02. Diagnosis. Must be identified by a physician or other practitioner of the healing arts as having one (1) of the diagnoses found in Subsections 726.03 through 726.0~~5~~4 of this rule. ~~*(5-8-09)*~~( )

~~***03. Developmental Delay or Disability.*** *A physical or mental condition which has a high probability of resulting in developmental delay or disability, or children who meet the definition of developmental disability as defined in Section 66-402, Idaho Code.* *(3-19-07)*~~

0~~4~~3. Special Health Care Needs. Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability. (3-19-07)

0~~5~~4. Serious Emotional Disturbance (SED). Have a serious emotional disturbance (SED) with an expected duration of at least one (1) year. The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code. (3-19-07)

a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and (3-19-07)

b. Requires sustained treatment interventions; and (3-19-07)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-19-07)

d. The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires that the child scores in the "moderate" impairment range in at least two (2) of the subscales. One (1) of the two (2) must be from the following: (5-8-09)

i. Self-Harmful Behavior; (3-19-07)

ii. Moods/Emotions; or (3-19-07)

iii. Thinking. (3-19-07)

e. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (3-19-07)

0~~6~~5. Need Assistance. Have one (1) or more of the following problems in Subsection726.0~~6~~5.a. through 726.06.e. of this rule associated with their diagnosis: ~~(5-8-09)~~( )

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (5-8-09)

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (5-8-09)

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (5-8-09)

d. Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)

e. The child requires multiple service providers and treatments. (3-19-07)

~~***07. Eligibility for Infants and Toddlers.***~~ ~~*(5-8-09)*~~

~~***a.*** *Birth through thirty-six (36) months of age;*~~ ~~*(5-8-09)*~~

~~***b.*** *Must be identified by a physician or other practitioner of the healing arts to have a condition requiring early intervention services; and*~~ ~~*(5-8-09)*~~

~~***c.*** *Must meet the eligibility requirements for early intervention services administered by the Idaho Infant Toddler Program.*~~ ~~*(5-8-09)*~~

(BREAK IN CONTINUITY OF SECTIONS)

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (5-8-09)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (5-8-09)

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (5-8-09)

b. That a paraprofessional is not a supervisor. (5-8-09)

03. Agency Supervisor Required Education and Experience. (5-8-09)

a. Master's Degree in a a human services field from a nationally accredited university or college, and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

c. Be a licensed professional nurse (RN), and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

d. For mental health service coordination, the supervisor must have obtained the required supervised work experience in a mental health treatment setting with the serious and persistent mentally ill population. (5-8-09)

04. Service Coordinator Education and Experience. (5-8-09)

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Be a licensed professional nurse (RN); and have twelve (12) months work experience with the population being served. (5-8-09)

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. (5-8-09)

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (5-8-09)

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (5-8-09)

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (5-8-09)

c. Have twelve (12) months supervised work experience with the population being served. (5-8-09)

06. Limitations on Services Delivered by Paraprofessionals. (5-8-09)

a. Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.07 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. (5-8-09)

b. Mental Health Service Coordination does not allow for service provision by paraprofessionals. (5-8-09)

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (5-8-09)

~~***10. Infant Toddler Provider Network**. Service coordination for children from birth through thirty-six (36) months may only be provided through the Infant Toddler network of service coordinators.* (5-8-09)~~

(BREAK IN CONTINUITY OF SECTIONS)

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (5-8-09)

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (5-8-09)

02. Plan Content. Plans must include the following: (5-8-09)

a. A list of problems and needs identified during the assessment; (5-8-09)

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (5-8-09)

c. Concrete, measurable goals and objectives to be achieved by the participant; (5-8-09)

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (5-8-09)

e. Documentation of who has been involved in the service planning, including the participant's involvement; (5-8-09)

f. Schedules for service coordination monitoring, progress review, and reassessment; (5-8-09)

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps; (5-8-09)

h. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (5-8-09)

i. Time frames for achievement of the goals and objectives. (5-8-09)

03. Adult Developmental Disability Service Coordination Plan. The plan for adults with developmental disabilities must be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. (5-8-09)

~~***04. Children Birth Through Thirty Six Months Service Coordination Plan**. For children from birth through thirty-six (36) months, service coordination outcomes and objectives must be incorporated into an individualized family service plan for the child according to the Individuals with Disabilities Education Act, Part C. The plan must be developed jointly with the family and appropriate multi-disciplinary team. The team consists of the service coordinator, family members, and professionals that conduct evaluations and may include service providers.~~ ~~*(5-8-09)*~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1204

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also House bill 609 (2012).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

These rule changes are being made to bring this chapter into alignment with the changes made to Section 56-255(5)(c), Idaho Code, as amended under House Bill 609 (2012). Section 56-255(5)(c), Idaho Code (as amended), now states that "participants on the aged and disabled (A&D) waiver and the developmental disability (DD) waiver shall have access to dental services that reflect evidence-based practice." The Department is adding dental benefits to these two waivers to comply with the new state law, and is revising the rules to reflect these changes.

House Bill 609 also amended Section 56-264(2)(6), Idaho Code, to allow concurrent skill training by mental health providers and developmental disability providers, so long as the mental health skills training relates to the mental illness and is provided by professionals who possess mental health expertise, and the training provided by the developmental disability provider relates to the developmental disability. These services may not be duplicative of each other. The Department is aligning the rules regarding skill training with the changes in the law.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 4, 2012, Idaho Administrative Bulletin, **Vol. 12-7, pages 53 through 90**.

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

Dental benefits will have an estimated fiscal impact of $600,000 to the state general fund. Skill training will have an estimated fiscal impact of $900,000 to the state general fund. The net cost to the state general fund is projected to be $1,500,000.

Note: HB 609 provided for these funds and they are included in the SFY 2013 budget for the Division of Medicaid.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Wasserman at (208) 287-1156.

DATED this 4th day of October, 2012.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2012**.

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 by Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also House Bill 609 (2012).

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 July 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Rule changes are being made to bring this chapter into alignment with the changes made to Section 56-255(5)(c), Idaho Code, as amended under House Bill 609 (2012). Section 56-255(5)(c), Idaho Code (as amended), now states that "participants on the aged and disabled (A&D) waiver and the developmental disability (DD) waiver shall have access to dental services that reflect evidence-based practice." The Department is adding dental benefits to these two waivers to comply with the new state law, and revise the rules to reflect these changes.

House Bill 609 also amended Section 56-264(2)(6), Idaho Code, to allow concurrent skill training by mental health providers and developmental disability providers, so long as the mental health skills training relates to the mental illness and is provided by professionals who possess mental health expertise, and the training provided by the developmental disability provider relates to the developmental disability. These services may not be duplicative of each other. The Department is aligning the rules regarding skill training with the changes in the law.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is being done to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 609 (2012).

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

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

Dental benefits will have an estimated fiscal impact of $600,000 to the state general fund. Skill training will have an estimated fiscal impact of $900,000 to the state general fund. The net cost to the state general fund is projected to be $1,500,000.

Note: HB 609 provided for these funds and they are included in the SFY 2013 budget for the Division of Medicaid.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done in order to bring this chapter into compliance with House Bill 609 (2012). Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Mark Wasserman at (208) 287-1156.

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 July 25, 2012.

DATED this 8th day of June, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1204

082. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Enhanced Plan are eligible for Idaho Smiles dental benefits described in Section 083 of these rules. Adults who are eligible for Medicaid's HCBS Aged and Disabled (A&D) Waiver or Developmental Disabilities (DD) Waiver are eligible for Idaho Smiles adult dental benefits and additional dental services described in Section 326.09 and Section 703.13 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles.
~~(3-29-12)~~( )

083. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may require authorization from the Idaho Smiles contractor.
(3-29-12)

01. Dental Coverage for Children. Children are covered for dental services that include: (3-29-12)

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery;
(3-29-12)

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. (3-29-12)

02. Children's Orthodontics Limitations. Orthodontics are limited to children who meet the Enhanced Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules.
(3-29-12)

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant and who are not covered under the A&D or DD Waivers are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 083.03 - ADULT DENTAL SERVICES CODES

Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film

TABLE 083.03 - ADULT DENTAL SERVICES CODES	
Dental Code	**Description**
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abscess
D7511	Incision and drainage of abscess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

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

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. (3-29-12)

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 114 of these rules. The comprehensive diagnostic assessment for enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. ~~*Participants who receive skill training can only receive training from one (1) type of service, depending on their eligibility.*~~
~~*(3-29-12)*~~( )

01. General Participant Eligibility Criteria. The medical record must have documented evidence of a history and physical examination that has been completed by a participant's primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service. Participants who are in crisis as described at Subsection 123.04 of this rule may receive mental health services prior to obtaining a history and physical examination. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and documented in the comprehensive diagnostic assessment: (5-8-09)

a. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant. (5-8-09)

b. The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-2-08)

c. Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services: (4-2-08)

i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (4-2-08)

ii. Participants needing more restrictive care or inpatient care; and (4-2-08)

iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (4-2-08)

02. Eligibility Criteria for Children. To be eligible for services, a participant under

the age of eighteen (18) must have a serious emotional disturbance (SED). (5-8-09)

03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI). (5-8-09)

04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (4-2-08)

a. Children must meet Subsections 112.01 and 112.02 of this rule. (4-2-08)

b. Adults must meet Subsections 112.01 and 112.03 of this rule. (4-2-08)

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services for Children. ( )

a. To be eligible for the PSR services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.01 and 112.02 of this rule and must experience a substantial impairment in functioning. ( )

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

c. A child's level and type of functional impairment must be documented in the medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. ( )

d. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: self-harmful behavior, moods/emotions, or thinking. ~~*(3-29-12)*~~( )

~~***a.*** *Self-harmful behavior;* *(4-2-08)*~~

~~***b.*** *Moods/Emotions; or* *(4-2-08)*~~

~~***c.*** *Thinking.* *(4-2-08)*~~

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

a. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.~~a~~c.i. through 112.06.~~h~~c.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. ( )

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

c. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the adult's level and type of functional impairment must be documented in the medical record in the following areas: ~~(3-29-12)~~( )

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

~~b~~ii. **Financial;** (4-2-08)

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

~~d~~iv. **Family;** (4-2-08)

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

~~f~~vi. **Housing;** (4-2-08)

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

~~h~~viii. **Health/medical.** (4-2-08)

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and documented in the medical record within ten (10) days of discharge. (5-8-09)

i. Up to two (2) hours of plan development hours may be used for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based on the participant's hospital records

and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Section 114 of these rules. (5-8-09)

ii. Upon initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. A comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. (3-29-12)

b. In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the plan must be updated and the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DESCRIPTIONS.

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to twelve (12) hours per week per eligible participant. (5-8-09)

a. In order to be considered a partial care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and outcomes; and (3-29-12)

iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (5-8-09)

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation, or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. Participants who receive skill training in Partial Care cannot receive skill training in psychosocial rehabilitation~~, developmental therapy, intensive behavioral intervention, or residential habilitation~~ services. ~~(3-29-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR agency services, unless otherwise authorized by the Department. (5-8-09)

01. Assessment. Assessment services must not exceed four (4) hours per participant annually. The following assessments are included in this limitation: (3-29-12)

a. Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually; (3-29-12)

b. Occupational Therapy Assessment. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment. (5-8-09)

02. Psychological and Neuropsychological Testing. Testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (3-29-12)

03. Individualized Treatment Plan. Two (2) hours are available for the development of the participant's initial treatment plan. Following the development of the initial treatment plan, all subsequent treatment must be based on timely updates to the initial plan. Treatment plan updates are considered part of the content of care and should occur as an integral part of the participant's treatment experience. (3-29-12)

04. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. Services beyond six (6) hours weekly must be prior-authorized. (5-8-09)

05. Crisis Intervention Service. A maximum of ten (10) hours of crisis support in a community may be authorized per crisis per seven (7) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. This limitation is in addition to any other PSR service hours within that same time frame. (5-8-09)

06. Skill Training and Community Reintegration. Services are limited to five (5) hours weekly in any combination of individual or group skill training and community reintegration for eligible participants up to twenty-one (21) years of age. For participants aged twenty-one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. Participants who receive skill training in psychosocial rehabilitation cannot receive skill training in partial care~~, *developmental therapy, intensive behavioral intervention, or residential habilitation services*~~. Participants with both a developmental disability diagnosis and a qualifying mental health diagnosis, who want to receive skill training services from a PSR agency provider in addition to a developmental disability service provider, must obtain authorization from the Department prior to service implementation. ~~*(3-29-12)*~~( )

07. Pharmacological Management. Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by an Occupational Therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)

09. Place of Service. PSR agency services are to be home and community-based. (5-8-09)

a. PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is necessary to maximize the impact of the service. (5-8-09)

b. PSR agency services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

b. Assistance with activities of daily living; (3-19-07)

c. Meals, including special diets; (3-19-07)

d. Housekeeping; (3-19-07)

e. Laundry; (3-19-07)

f. Transportation; (3-19-07)

g. Opportunities for socialization; (3-19-07)

h. Recreation; and (3-19-07)

i. Assistance with personal finances. (3-19-07)

j. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated

to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. (3-30-07)

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-19-07)

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

a. Intermittent Assistance may include the following. (3-19-07)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in their home. (3-19-07)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)

09. Dental Services. Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. ( )

~~09~~10. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)

a. Rent or own their own home; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no regular caretaker for extended periods of time; and (3-19-07)

d. Are unable to prepare a balanced meal. (3-19-07)

1~~0~~1. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-19-07)

1~~1~~2. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of

direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12~~2~~3. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caretaker for extended periods of time; and (3-19-07)

d. Would otherwise require extensive routine supervision. (3-19-07)

13~~3~~4. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14~~4~~5. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

15~~5~~6. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (3-19-07)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

167**. Habilitation**. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (4-2-08)

1~~7~~8. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-30-07)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer’s participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-30-07)

1~~8~~9. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

329. AGED OR DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," including: (4-2-08)

i. Companion services; (4-2-08)

ii. Chore services; and (4-2-08)

iii. Respite care services. (4-2-08)

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-2-08)

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

07. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-19-07)

08. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-2-08)

09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

10. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (3-19-07)

11. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks History and Background Checks." (4-2-08)

12. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-19-07)

13. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

14. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History

and Background Checks." (4-2-08)

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

16. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

17. Residential Habilitation Supported Living Provider Qualifications. Residential habilitation supported living services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-29-12)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable diseases; (3-30-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services qualified by a program coordinator who is approved by the Department. (3-29-12)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

e. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

18. Residential Habilitation Program Coordination for Certified Family Home Providers. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes" and must receive residential habilitation program coordination from a qualified program coordinator approved by the Department. Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-29-12)

19. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

20. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

21. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct

care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

22. Dental Services. Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ( )

(BREAK IN CONTINUITY OF SECTIONS)

651. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. (7-1-11)

01. Required DDA Services. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement. (7-1-11)

a. Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (7-1-11)

b. When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. (7-1-11)

02. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. ~~*Developmental therapy will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* (3-29-12)~~( )

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive

language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-11)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-11)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-11)

03. Psychotherapy Services. The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service: (7-1-11)

a. Individual psychotherapy; (7-1-11)

b. Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and (7-1-11)

c. Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. (7-1-11)

d. Psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. (3-29-12)

e. Psychotherapy services must be provided by one (1) of the following qualified professionals: (7-1-11)

i. Licensed Psychiatrist; (7-1-11)

ii. Licensed Physician; (7-1-11)

iii Licensed Psychologist; (7-1-11)

iv. Licensed Clinical Social Worker; (7-1-11)

v. Licensed Clinical Professional Counselor; (7-1-11)

vi. Licensed Marriage and Family Therapist; (7-1-11)

vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; (7-1-11)

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.e.i. through 651.03.e.vii. of this rule; (7-1-11)

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

x. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (7-1-11)

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-11)

04. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

05. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

06. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Speech-language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. (7-1-11)

07. Optional Services. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, and Intensive Behavioral Intervention (IBI). All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (3-29-12)

08. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency, and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (7-1-11)

09. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. (7-1-11)

a. Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. (7-1-11)

b. On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. (7-1-11)

c. Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: (7-1-11)

i. Psychiatrist; (7-1-11)

ii. Physician or other practitioner of the healing arts; (7-1-11)

iii. Psychologist; (7-1-11)

iv. Clinical social worker; or (7-1-11)

v. Clinical professional counselor. (7-1-11)

10. Community Crisis Supports. Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. (7-1-11)

11. Intensive Behavioral Intervention. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. (7-1-11)

a. IBI is limited to a lifetime limit of thirty-six (36) months. (7-1-11)

b. The DDA must receive prior authorization from the Department prior to delivering IBI services. (7-1-11)

c. IBI must only be delivered on an individualized, one-to-one (1 to 1) basis.(7-1-11)

~~***d.*** *Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* ***(3-29-12)***~~

~~e~~**d.** After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services. (3-29-12)

~~f~~**e.** Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of this rule. (3-29-12)

~~g~~**f.** IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-29-12)

12. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

13. Limitations on DDA Services. DDA therapy services may not exceed the limitations as specified below. (3-29-12)

a. The combination of therapy services listed in Subsections 651.02 through 651.06, and 651.11 of this rule must not exceed twenty-two (22) hours per week. (3-29-12)

b. Therapy services listed in Subsections 651.02 through 651.06, and 651.11 of this rule, provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. (3-29-12)

c. When an HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (7-1-11)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

657. DDA SERVICES: DDA PROVIDER QUALIFICATIONS AND DUTIES.

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. (7-1-11)

02. Counselor, Licensed Clinical Professional. A person licensed to practice as a clinical professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

03. Counselor, Licensed Professional. A person licensed to practice as a professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

04. Marriage and Family Therapist. (7-1-11)

a. Licensed Marriage and Family Therapist. A person licensed to practice as a marriage and family therapist in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

b. Registered Marriage and Family Therapist Intern. A person registered to practice as a marriage and family therapist intern under the direct supervision of a Licensed Marriage and Family Therapist, in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

05. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho

Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

06. Developmental Specialist for Children Three Through Seventeen. A Developmental Specialist providing developmental assessment and therapy services to children ages three (3) through seventeen (17) must meet the requirements for a Developmental Specialist for adults, and must also meet the following requirements: (7-1-11)

a. Successfully complete a competency course approved by the Department that relates to developmental assessment and therapy for children; and (7-1-11)

b. Pass a competency examination approved by the Department. (7-1-11)

07. Developmental Therapy Paraprofessionals Delivering Services to Participants Age Three and Older. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children age (3) and older if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-11)

08. Developmental Specialist for Children Birth to Three. (7-1-11)

a. To provide developmental assessments and therapy to children birth to three (3) years of age, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

ii. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; (7-1-11)

iii. A bachelor's or masters degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

(1) Promotion of development and learning for children from birth to three (3) years; (7-1-11)

(2) Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

(3) Building family and community relationships to support early interventions; (7-1-11)

(4) Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

b. Electives closely related to the content under Subsection 657.08.a.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

c. A developmental specialist who possesses a bachelor's or master's degree listed above under Subsection 657.08.a.ii. of this rule, must have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with his approved, conditional hiring agreement. (7-1-11)

d. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. An individual who has an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as he demonstrates satisfactory progress on the plan and complete the requirements on the plan within three (3) years of his date of hire. (7-1-11)

09. Developmental Therapy Paraprofessionals Delivering Services to Children Birth to Three. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children birth to three (3) years of age if they are

under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. Developmental therapy paraprofessionals serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Be a high school graduate or have a GED; and (7-1-11)

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education or closely-related coursework; or (7-1-11)

d. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. (7-1-11)

10. Intensive Behavioral Intervention (IBI) Professional Delivering Services to Participants Three to Twenty-One. A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements: (7-1-11)

a. Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college. (7-1-11)

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. (7-1-11)

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410. (7-1-11)

11. IBI Paraprofessionals Delivering Services to Participants Three to Twenty-One. A certified IBI paraprofessional may be used to provide IBI under the supervision of a certified IBI professional and must comply with Section 658 of these rules. An IBI paraprofessional must also: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year of supervised experience working with children with developmental disabilities. The year of experience must be gained through paid employment or university practicum experience or internship and be documented to

include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. (7-1-11)

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410. (7-1-11)

12. IBI Professionals Delivering Services to Children Birth to Three. A person qualified to provide or direct the provision of IBI to children under three (3) years of age must meet the staff qualifications described under Subsections 657.08.a.ii. through 657.08.d. of these rules, 657.10.b. and 657.10.c. of these rules and the certification and training requirements above under Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)

13. IBI Paraprofessionals Delivering Services to Children Birth to Three. A paraprofessional serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Be a high school graduate or have a GED; and (7-1-11)

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) credits in child development, special education, or closely-related coursework; or (7-1-11)

d. Have three (3) years of documented experience providing care to infants, toddlers or children under five (5) years of age under the supervision of a child development professional, certified educator, or licensed therapist or Developmental Specialist. (7-1-11)

e. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410, and Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)

14. Nurse Practitioner. A licensed professional nurse (RN) who has met all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-11)

15. Occupational Therapist. A person qualified to conduct occupational therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (7-1-11)

16. Physical Therapist. A person qualified to conduct physical therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.05, "Licensure of Physical Therapists Idaho State Board of Medicine and Physical Therapist Assistants." (7-1-11)

17. Physician. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code. (7-1-11)

18. Physician Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-11)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (7-1-11)

b. Has satisfactorily completed a program for preparing physician's assistants that: (7-1-11)

i. Was at least one (1) academic year in length; and (7-1-11)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (7-1-11)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (7-1-11)

19. Psychiatric Nurse, Certified. A licensed professional nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (7-1-11)

20. Psychiatrist. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code, and who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. (7-1-11)

21. Psychologist. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-11)

22. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (7-1-11)

23. Social Worker, Licensed. A person licensed in accordance with the Social Work Licensing Act, Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

24. Masters Social Worker, Licensed. A person who is licensed as a masters social worker (LMSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

25. Clinical Social Worker, Licensed. A person who is licensed as a clinical social worker (LCSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

26. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. (7-1-11)

27. Requirements for Collaboration with Other Providers. ( )

a. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the Psychosocial Rehabilitation (PSR) plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ~~(7-1-11)~~( )

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. ( )

(BREAK IN CONTINUITY OF SECTIONS)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-11)

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; (7-1-11)

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-11)

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

d. Therapeutic consultation providers employed by a DDA must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-11)

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of crisis intervention must meet the following minimum qualifications: (7-1-11)

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.04 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual

training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. (7-1-11)

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-11)

09. Requirements for Collaboration with Other Providers. ( )

a. Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. ( )

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater

independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

~~***d.*** *Residential Habilitation services will not be reimbursed if a participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* (3-29-12)~~

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources

required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or

private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care cannot exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

13. Dental Services. Dental services include exams radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. ( )

1~~3~~4. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

1~~4~~5. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-29-12)

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-29-12)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

02. Residential Habilitation -- Certified Family Home (CFH). (3-29-12)

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides. (3-29-12)

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (3-29-12)

i. Be at least eighteen (18) years of age; (3-29-12)

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-29-12)

iii. Have current CPR and First Aid certifications; (3-29-12)

iv. Be free from communicable diseases; (3-29-12)

v. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. (3-29-12)

vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and (3-29-12)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-29-12)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (3-29-12)

i. Purpose and philosophy of services; (3-29-12)

ii. Service rules; (3-29-12)

iii. Policies and procedures; (3-29-12)

iv. Proper conduct in relating to waiver participants; (3-29-12)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-29-12)

vi. Participant rights; (3-29-12)

vii. Methods of supervising participants; (3-29-12)

viii. Working with individuals with developmental disabilities; and (3-29-12)

ix. Training specific to the needs of the participant. (3-29-12)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (3-29-12)

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (3-29-12)

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (3-29-12)

iii. Feeding; (3-29-12)

iv. Communication; (3-29-12)

v. Mobility; (3-29-12)

vi. Activities of daily living; (3-29-12)

vii. Body mechanics and lifting techniques; (3-29-12)

viii. Housekeeping techniques; and (3-29-12)

ix. Maintenance of a clean, safe, and healthy environment. (3-29-12)

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (3-29-12)

03. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

04. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

06. Transportation. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

07. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

08. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

09. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

10. Home Delivered Meals. Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must: (7-1-11)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

11. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

12. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

13. Adult Day Care. Providers of adult day care services must notify the Department or its contractor for residential habilitation program coordination, on behalf of the participant, if the adult day care is provided in a certified family home other than the participant's primary residence. The adult day care provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (3-29-12)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

14. Dental Services. Providers are credentialed by the contractor to ensure they meet

the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ( )

145. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1205

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is **October 1, 2012**. This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The changes to these rules are for clarification and correction to a reference. The original text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 411 through 426**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **October 1, 2012**.

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

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

Wednesday - October 24, 2012
9:00 a.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The changes to these rules implement new Behavioral Care Units (BCU) in nursing facilities (NFs) and intermediate care facilities for people with intellectual disabilities (ICFs/ID). The BCUs are designed to enhance a nursing facility resident's quality of life, quality of care, and enhance their functional and cognitive status and safety. Other changes in this docket continue reimbursement methodologies and rates based on current cost reporting years.

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

These rule changes provide for the health and safety of individuals living in NFs and ICFs/ID and confer a benefit by providing quality care and services to participants living in these facilities.

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

described herein: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department has held discussions with providers and stakeholders over several years to reflect an agreed upon reimbursement for Behavioral Care Units. This rulemaking addresses the issues from those meetings.

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

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 5th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1205

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate

medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. ( )

~~a~~**b.** "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

~~b~~**c.** "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.~~29~~30 in this rule. ~~(3-19-07)~~( )

~~c~~**d.** "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ( )

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. ( )

~~d~~**g.** Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

~~e~~**h.** "Urban Hospital-~~B~~based Nursing Facilit~~ies~~y" means a hospital-based nursing facilit~~ies~~y located within a metropolitan statistical area (MSA) as defined by the United States

Bureau of the Census. ~~*(3-19-07)*~~( )

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. ICF/ID Living Unit. The physical structure that an ICF/ID uses to house patients. (3-19-07)

17. Improvements. Improvements to assets which increase their utility or alter their use. (3-19-07)

18. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

19. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

20. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

21. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

22. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (3-19-07)

23. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

24. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

25. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

26. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

27. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

28. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

29. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

30. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

31. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

012. DEFINITIONS: L THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (3-19-07)

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (3-19-07)

03. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-19-07)

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-19-07)

05. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (3-19-07)

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-19-07)

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (3-19-07)

08. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (3-19-07)

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (3-19-07)

a. A relatively fixed location in the building; (3-19-07)

b. Capable of being moved, as distinguished from building equipment; (3-19-07)

c. A unit cost of five thousand dollars ($5000) or more; (3-19-07)

d. Sufficient size and identity to make control feasible by means of identification tags; and (3-19-07)

e. A minimum life of three (3) years. (3-19-07)

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

11. Medicaid. Idaho's Medical Assistance Program. (3-19-07)

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (3-19-07)

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (3-19-07)

14. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-19-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-19-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-19-07)

c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-19-07)

15. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-19-07)

16. Medicare Savings Program. The program formerly known as "Buy-In Coverage," where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. (3-19-07)

17. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (3-19-07)

18. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators

used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (3-19-07)

a. No fixed location and subject to use by various departments of the provider's facility; (3-19-07)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (3-19-07)

c. Subject to inventory control; (3-19-07)

d. Fairly large quantity in use; and (3-19-07)

e. A useful life of less than three (3) years. (3-19-07)

19. Necessary. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (3-19-07)

20. Negotiated Service Agreement (NSA). The plan reached by the resident and his representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (3-19-07)

21. Net Book Value. The historical cost of an asset, less accumulated depreciation. (3-19-07)

22. New Bed. Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a nursing facility is licensed on or after July 1, 1999. (3-19-07)

23. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (3-19-07)

24. Nonambulatory. Unable to walk without assistance. (3-19-07)

25. Nonprofit Organization. An organization whose purpose is to render services without regard to gains. (3-19-07)

26. Normalized Per Diem Cost. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. (3-19-07)

27. Nurse Practitioner. A licensed professional nurse (RN) who meets all the

applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

28. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for participants. It must be an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participant must require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. (3-19-07)

29. Nursing Facility Inflation Rate. See the definition of Inflation Factor in Subsection 011.~~17~~20 of these rules. ~~(3-19-07)~~( )

30. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (3-19-07)

31. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.08 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, rates will be calculated using audited cost reports ended in calendar year 2010 with no allowance for inflation to the rate ~~period~~ year of July 1, 2011, through June 30, 2012. For the rate years beginning July 1, 2012, and annually thereafter, rates will be calculated using audited cost reports for periods ended in the preceding calendar year with no allowance for inflation to the prospective rate period. ~~(3-21-12)~~( )

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of

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

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

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

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

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

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

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

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers. ~~(3-19-07)~~( )

06. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

07. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

08. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of ~~these~~ this rule~~s~~. ~~(3-19-07)~~( )

258. NURSING FACILITY: COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, the direct and indirect cost limits were calculated using the most recent ~~finalized~~ audited cost reports adjusted to the midpoint of the cost reporting year's end in calendar year 2010, to allow for no inflation to the rate year. For rate years beginning July 1, 2012, and annually thereafter, the direct and indirect cost limits will be calculated using the most recent audited cost reports adjusted to the midpoint of each provider's cost reporting year that is used to set the July 1 rate, to allow for no inflation to the rate year. ~~(3-21-12)~~( )

01. Percentage Above Bed-Weighted Median. ( )

a. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. ( )

b. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. ( )

c. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units. Percentages previously established for other provider class types not considered a behavioral care unit will remain unchanged. Once established, these percentages will remain in effect for future rate setting periods. ~~(3-19-07)~~( )

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with ~~freestanding and hospital-based~~ all nursing facilities included in the same array, and the bed-weighted median will be computed.

~~(3-19-07)~~( )

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with ~~freestanding and hospital- based~~ all nursing facilities included in the same array, and the bed-weighted median will be computed. ~~(3-19-07)~~( )

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. (3-29-10)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

~~**266. -- 269. (RESERVED)**~~

266. NURSING FACILITY: BEHAVIORAL CARE UNIT (BCU) AND RATE STRUCTURE.

Effective October 1, 2012, the additional direct care costs associated with BCU residents will remain in direct care costs subject to the direct care cost limitation. Those qualifying BCU nursing facility providers may have a direct care cost limitation higher than non-BCU nursing facility providers. BCU nursing facility providers will not receive an increased indirect care cost limitation. ( )

01. Determination. The BCU must have a qualifying program and have been providing care in the BCU to behavior residents as of July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility. ( )

02. BCU Routine Customary Charge. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU.

( )

03. Prospective Rate Setting. Beginning October 1, 2012, the direct care cost limit calculation for any special rate revenue offsets in the prior year related to one-to-one (1:1) staffing ratios, BCU, or increased staffing, will be reversed before calculating the cost limit. This revenue offset reversal excludes revenues related to special rate add-ons for ventilator-dependent or tracheostomy services. Rates will be calculated using the cost report ended in the calendar year prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit. ( )

04. Rates Effective October 1, 2012. For rates effective October 1, 2012, a nursing facility designated as a BCU during each nursing facility provider's cost report ended in calendar year 2011 must be identified. ( )

a. Days approved for a BCU during the 2011 cost report year must be identified. ( )

b. To qualify as a BCU, Medicaid BCU days identified in Subsection 266.04.a. of this rule, are divided by total days in the nursing facility and that calculation must equal or exceed a minimum of fifteen percent (15%). ( )

05. Annual Rates Beginning July 1, 2013. For annual rates beginning July 1, 2013, once a rate has been set as provided in Subsection 266.03 of this rule, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by: ( )

a. BCU days, regardless of payer source, are divided by the total occupied days in the nursing facility and that calculation must equal or exceed a minimum of twenty percent (20%). ( )

b. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year; ( )

i. The Department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the MDS for each selected sample participant, along with related census information, and other requested information to the Department. ( )

ii. The Department will review this information to determine that the participants meet the requirements of Subsection 266.06 of this rule and calculate the percentage of BCU days to the total occupied days in the facility to determine whether the facility meets the BCU eligibility requirement in Subsection 266.05.a. of this rule. ( )

06. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in the participants' MDS assessment: ( )

a. Medically based behavior disorder which causes a significantly diminished

capacity for judgment, retention of information, or decision making skills, or medically based mental health disorder of diagnosis and has a high level resource use; and ( )

b. Must have a history or demonstrate need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff, evidenced by one (1) or more of the following: ( )

i. Wandering behaviors; ( )

ii. Verbally abusive behaviors; ( )

iii. Physically abusive behaviors; ( )

iv. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents; ( )

v. Behaviors that resist care; or ( )

vi. Does not meet unit discharge criteria outlined in Subsection 266.13 of this rule. ( )

c. A behavior baseline profile must be established for each participant; ( )

d. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or safety. ( )

07. BCU Annual Renewal. The facility must request continuation in the BCU program annually. The request must include the following: ( )

a. A description of the facility's program that includes the required components in Subsections 266.05 and 266.06 of this rule; and ( )

b. A profile of the types of behavior of participants served and any restrictions the facility has adopted. ( )

08. Administrative and Staffing Requirements. ( )

a. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed. ( )

b. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for twenty-four hours a day/seven days a week (24/7) emergency services. Consultants must make at least quarterly site visits and be available to participate in Behavior Management Team meetings as needed. ( )

c. Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Social Worker (LSW) with behavioral experience must be available to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and Behavior Management Team meetings as needed. ( )

09. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include but are not limited to psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed, and may participate in person or by telephone. ( )

10. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on: ( )

a. Assessment and prevention; ( )

b. Medication and side effects; ( )

c. Effects of disease process on mood state; ( )

d. Safety techniques; ( )

e. Deflecting aggression or target behaviors; ( )

f. Comprehensive environmental intervention; ( )

g. Stress management; and ( )

h. Documentation and charting. ( )

11. Yearly Training. Yearly training for behavioral interventions and safety techniques is required for staff. ( )

12. Care Planning, Behavioral Management, and Programming. Individualized care plans, based on assessments of cognitive and functional abilities, along with behavior analysis to create a strategy for prevention and intervention that are documented for each participant and include the following: ( )

a. Thirty (30) day assessments of progress made by each participant, must be completed, documented, and reviewed by the facility's behavioral management team. ( )

b. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used must be documented for each participant. ( )

c. Attempts to involve family and responsible parties with the participant through

visits, training, outings, or appropriate communications, must be documented. ( )

d. Recreational and activity programming must be targeted to specific needs of each individual participant and the behaviors each participant exhibits must be documented. ( )

e. Integration for appropriate social interactions must be used when appropriate for each individual participant. ( )

f. Community for transition must be used when appropriate for each individual participant. ( )

g. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming. ( )

13. Discharge Criteria. The BCU must maintain and document discharge criteria as follows: ( )

a. Document improvement in ability to function that would enable transfer to less-restrictive environment. ( )

b. Document lack of benefit from specialized programs offered in BCU. ( )

c. Document consistent refusals by participant or responsible party to allow interventions that are determined to be helpful, ( )

d. Document acute danger to self or others that cannot be managed by staffing in the BCU. ( )

e. Document acute physical illness or complications requiring a higher level of medical care than available in the facility. ( )

f. A nursing facility provider that is approved for one-hundred percent (100%) behavioral participants will be exempt for the discharge criteria provided in Subsections 266.13.a. through 266.13.e. of this rule. ( )

14. Termination of BCU Status. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year. ( )

15. Refusal of Admissions. These rules do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility. ( )

267. NURSING FACILITY: NEW BEHAVIORAL CARE UNIT (BCU).

01. Criteria to Qualify as a New BCU. A nursing facility provider must meet the following criteria to qualify as a new BCU nursing facility provider: ( )

a. BCU days from the cost report period, regardless of payer source, are divided by

the total occupied days in the nursing facility, and that calculation must equal or exceed a minimum of twenty percent (20%). ( )

b. A qualifying cost report must demonstrate that the nursing facility provider has a qualifying program in place with residents. ( )

02. First Cost Reporting Year. No BCU eligibility, or increased direct care cost limit will be allowed in the first cost reporting year the BCU program is added. ( )

03. Qualifying Report in Tandem with BCU Eligibility. Once a qualifying cost report is submitted for the BCU program, and the nursing facility provider qualifies in tandem with the BCU eligibility criteria, the cost report will be used to set a prospective rate effective the following July 1 rate period with the increased direct care cost limit. ( )

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).

An existing nursing facility provider that elects to add a BCU after July 1, 2011, may be deemed eligible after meeting the following requirements: ( )

01. Qualifying Cost Report. A qualifying cost report that demonstrates a qualifying program is in place with residents and meets the criteria in Section 282 of these rules. ( )

02. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. ( )

03. BCU Payments. No BCU payments or increased direct care cost limits will be allowed in the first cost reporting year the program is added. Once a qualifying cost report is submitted, and the provider qualifies in tandem with the BCU criteria, the cost report will be used to set a prospective rate, effective with the following July 1 rate period with the increased direct care cost limit. ( )

269. NURSING FACILITY: NEW OWNER OF AN EXISTING NURSING FACILITY WITH A BEHAVIORAL CARE UNIT (BCU).

01. New Owner Elects to Continue BCU. An existing nursing facility that is considered a BCU will continue to be a BCU, if the new owner elects to continue to provide these services. The new owner will receive a rate calculated according to the current change of ownership rules in Section 261 of these rules. The prior owner's cost report will be used until the new owner has a qualifying cost report. They BCU will continue to qualify for the higher direct care cost limit the previous owner was allowed. ( )

02. New Owner Does Not Elect to Continue BCU. If the new owner does not elect to operate the BCU, the prior owner's cost report will be used. The direct care cost limit will be adjusted down to that of the non-BCU nursing facility. ( )

270. NURSING FACILITY: SPECIAL RATES.

A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in

addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated ~~pursuant to the principles found in Section 56-265, Idaho Code~~. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions ~~of Section 56-265, Idaho Code, and~~ in these rules. ~~(3-19-07)~~( )

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days. (3-4-11)

02. Effective Date. Upon approval, a special rate is effective on the date the application was received. (3-4-11)

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. (3-19-07)

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. (3-19-07)

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of ~~these~~ this rule~~s~~ provide clarification of how special rates are paid under the prospective payment system. ~~(3-19-07)~~( )

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.~~d~~c. of ~~these~~ this rule~~s~~. ~~(3-19-07)~~( )

~~***a.*** *Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules.* *(3-19-07)*~~

~~*i.* *If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit.* *(3-19-07)*~~

~~*ii.* *If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit.* *(3-19-07)*~~

~~*iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. (3-19-07)*~~

~~*iv*~~**a.** One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (3-19-07)

~~*v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. (3-19-07)*~~

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules ~~*or adequately addressed in the current RUG system,*~~ as determined by the Department, are reimbursed in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. ~~*(3-4-11)*~~( )

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. ~~*The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care.*~~ In the case of residents who are ventilator-dependent and who receive tracheostomy ~~*residents*~~ care, ~~*a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents that is higher than the amount indicated on the resident's most recent Medicaid RUG score. The add-on is calculated following the provisions in Subsection 270.06.d. of this rule, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment and non-therapy supplies following the provision in Subsection 270.06.b. of this rule. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care.*~~ the special add-on amount to the facility's rate for approved residents receiving this care, is determined by combining the following two (2) components: ~~*(3-4-11)*~~( )

i. Calculation of a staffing add-on for the cost, if any, for additional direct care staff required in meeting the exceptional needs of these residents. The hourly add-on rate is equal to the current WAHR CNA *or current WAHR RN* wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA minimum daily staffing time adjusted for the appropriate skill level of care staff; and ( )

ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.*b*. of this rule. ( )

~~***d.*** *Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios to meet the exceptional needs of that resident. If the staffing level is higher than the amount indicated on the resident's most recent Medicaid RUG score, the facility may request a special rate. If the resident qualifies for a special rate for additional direct care staff required to meet the exceptional needs of that resident, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA Minimum daily staffing time.* *(3-4-11)*~~

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains ~~*non-unit*~~ special rate costs, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs. ~~*(3-19-07)*~~( )

08. Special Rate for Providers that Change Ownership or Close. When a facility changes ownership or closes, a closing cost report is not required. Special rate payments made in the closing cost reporting period may be reviewed by the Department. ( )

(BREAK IN CONTINUITY OF SECTIONS)

622. ICF/ID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider ~~*will*~~ must report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, exempt costs, and excluded costs. Except as otherwise provided in this section, rates calculated for state fiscal year 2012 (July 1, 2011 through June 30, 2012) will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. Rates effective July 1, 2012, and every July 1 thereafter, will be calculated by using audited cost reports ended in the calendar year two (2) years prior to each July 1 (July 1, 2012, rates will use cost reports ended in calendar year 2010 and so forth), with no cost or cost limit adjustments for inflation. ~~*(3-21-12)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.25 - IDAHO MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

DOCKET NO. 16-0325-1201 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, and 56-1054, Idaho Code; also the American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Department is adopting a new chapter of rules to administer the Medicaid Electronic Health Record (EHR) Incentive Program in which it has opted to participate. Section 4201 of the ARRA established this voluntary program to disburse incentive payments to Medicaid providers who adopt, implement, or upgrade to become meaningful users of certified electronic health record systems.

This new chapter of rules encompasses the Medicaid EHR Incentive Program state criteria for eligible professionals and eligible hospitals.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 4, 2012, Idaho Administrative Bulletin, **Vol. 12-7, pages 91 through 97**.

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

The state general fund impact is neutral for this rulemaking. The Department will use existing resources to make this program operational. Through the authority of the ARRA the Department will pay 100% federally funded incentive payments to eligible providers in Idaho to purchase and maintain certified Electronic Health Record systems.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 4th day of October, 2012.

Tamara Prisock
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2012**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized by Sections 56-202, 56-203, and 56-1054, Idaho Code; also the American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495.

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 July 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department is adopting a new chapter of rules to administer the Medicaid Electronic Health Record (EHR) Incentive Program in which it has opted to participate. Section 4201 of the ARRA established this voluntary program to disburse incentive payments to Medicaid providers who adopt, implement, or upgrade to become meaningful users of certified electronic health record systems.

This new chapter of rules will encompass the Medicaid EHR Incentive Program state criteria for eligible professionals and eligible hospitals.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is being done to confer a benefit in accordance with the ARRA, Section 4201 and 42 CFR Part 495.

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

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

The state general fund impact is neutral for this rulemaking. The Department will use existing resources to make this program operational. Through the authority of the ARRA the Department will pay 100% federally funded incentive payments to eligible providers in Idaho to purchase and maintain certified Electronic Health Record systems.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the federal Centers for Medicare and Medicaid Services (CMS) is implementing the program and the money is enhancing the efficiency of providers and improving patients' experience. Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, 42 CFR Part 495, revised October 1, 2011 **(http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5.pdf)**, is being incorporated by reference into these rules to give it the force and effect of law under these rules. These federal regulations are not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 14th day of June, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0325-1201

IDAPA 16
TITLE 03
CHAPTER 25

16.03.25 - IDAHO MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

000. LEGAL AUTHORITY.

01. Rulemaking Authority. Under Sections 56-202, 56-203, and 56-1054, Idaho Code, the Idaho Department of Health and Welfare has the authority to adopt rules regarding the Idaho Medicaid Electronic Health Record (EHR) Incentive Program. ( )

02. General Administrative Authority. The American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495, provide the basic authority for administration of this federal program. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.25, "Idaho Medicaid Electronic Health Record (EHR) Incentive Program." ( )

02. Scope. These rules: ( )

a. Establish the Medicaid Electronic Health Record (EHR) Incentive Program for Idaho covered under 42 CFR Part 495. ( )

b. Provide the Medicaid EHR Incentive Program criteria for participation of qualified eligible professionals and hospitals that adopt, implement, or upgrade to become meaningful users of certified electronic health record systems in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA), Section 4201. ( )

c. Provide for the audit of providers receiving incentive payments. ( )

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection at the location identified under Subsection 005.06 of these rules and in accordance with Section 006 of these rules. ( )

003. ADMINISTRATIVE APPEALS.

All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.

The Department has incorporated by reference 42 CFR Part 495, "Medicare and Medicaid Programs," revised October 1, 2011. A hardcopy is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5.pdf. ( )

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. ( )

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ( )

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ( )

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ( )

05. Internet Website. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. ( )

06. Division of Medicaid. The Department's Division of Medicaid is located at 3232 Elder Street, Boise, ID 83705; Phone: (208) 334-5747. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT REQUESTS.

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 009. (RESERVED).

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter of rules the following terms apply: ( )

01. Acute Care Hospital. A health care facility, including a critical access hospital, with a CMS Certification Number that ends in 0001-0879 or 1300-1399. An acute care hospital: ( )

a. Must have ten percent (10%) Medicaid patient discharges; ( )

b. Is a primary health care facility where the average length of patient stay is twenty-five (25) days or fewer. ( )

02. Adopt, Implement, or Upgrade (AIU). ( )

a. Acquire, purchase, or secure access to certified EHR technology; ( )

b. Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or ( )

c. Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology. ( )

03. Attestation. Signature as a witness by each professional or hospital who applies to the EHR program signifying the information they have provided is true and genuine and affirms that they meet the EHR incentive payment eligibility criteria. ( )

04. Border States. The border states for Idaho are: Washington, Oregon, Nevada, Utah, Wyoming, and Montana. ( )

05. Certified EHR Technology. As defined in 42 CFR Section 495.4 (2010) and 45 CFR Section 170.102 (2010 and 2011), in accordance with the Office of the National Coordinator for Health Information Technology EHR certification criteria. ( )

06. Children's Hospital. As referenced in 42 CFR Section 495.302, a separately certified hospital, either freestanding or hospital-within-hospital, that has a CMS Certification Number that ends in 3300–3399 and predominantly treats individuals under twenty-one (21) years of age. ( )

07. CMS. Centers for Medicare and Medicaid Services. ( )

08. Critical Access Hospital (CAH). A small, generally geographically remote facility that provides outpatient and inpatient hospital services to people in rural areas. The designation was established by law, for special payments under the Medicare program. A critical access hospital: ( )

a. Is located in a rural area and provides 24-hour emergency services; ( )

b. Has an average length-of-stay for its patients of ninety-six (96) hours or less; ( )

c. Is located more than thirty-five (35) miles (or more than fifteen (15) miles in areas with mountainous terrain) from the nearest hospital or is designated by the State as a "necessary provider"; and ( )

d. Has no more than twenty-five (25) beds. ( )

09. **CY**. Calendar Year. ( )

10. **Dentist**. A person who meets all the applicable requirements to practice as a licensed dentist under IDAPA 19.01.01, "Rules of the Idaho State Board of Dentistry." ( )

11. **Department**. The Idaho Department of Health and Welfare. ( )

12. **EHR**. Electronic Health Record. ( )

13. **Eligible Hospital**. An acute care hospital with at least ten percent (10%) Medicaid patient volume or a children's hospital. ( )

14. **Eligible Professional**. A physician, dentist, nurse practitioner (including a nurse-midwife nurse practitioner), or a physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a physician assistant and meets patient volume requirements described in 42 CFR Section 495.306. ( )

15. **Eligible Provider**. Eligible hospital or eligible professional. ( )

16. **Eligible Provider, Hospital-Based**. In accordance with 42 CFR Section 495.4, an eligible provider who furnishes ninety (90) percent or more of his or her covered professional services in a hospital setting in the CY preceding the payment year. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. ( )

17. **Encounter**. ( )

a. For an eligible hospital either may apply: ( )

i. Services rendered to an individual per inpatient discharge; or ( )

ii. Services rendered to an individual in an emergency department on any one (1) day; ( )

b. For an eligible professional, services rendered to an individual on any one (1) day. ( )

18. **Enrolled Provider**. A hospital or health care practitioner who is actively registered with the Department's Idaho Medicaid EHR Incentive Program. ( )

19. **Federal Fiscal Year (FFY)**. The federal fiscal year is from October 1 to September 30. ( )

20. **Federally Qualified Health Center (FQHC)**. A federal designation for a medical entity that meets the requirements of 42 U.S.C. Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. ( )

21. Hospital-Based. An eligibility criterion that excludes an eligible professional from participating in the Medicaid EHR Incentive Program when an eligible professional furnishes 90 percent (90%) or more of the eligible professional's Medicaid covered services in a hospital emergency room (place of service code 23), or inpatient hospital (place of service code 21) in the CY preceding the payment year. ( )

22. Meaningful EHR User. An eligible provider that, for an EHR reporting period for a payment year, demonstrates (in accordance with 42 CFR Section 495.8) meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in 42 CFR Section 495.6 and as prescribed by 42 CFR Part 495. ( )

23. Nurse Practitioner (NP). A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," and as defined in 42 CFR Section 440.166. ( )

24. Payment Year. ( )

a. The CY for an eligible professional; or ( )

b. The FFY for an eligible hospital. ( )

25. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a State or United States territory, and who performs services as defined in 42 CFR Section 440.50. ( )

26. Physician Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," and who performs services as defined in 42 CFR Section 440.60. ( )

011. -- 099. (RESERVED).

Eligibility Determination
(Sections 100 through 399)

100. ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM ELIGIBILITY.

01. Providers and Hospitals Eligible to Participate in the EHR Incentive Program. The Department administers the federal EHR Incentive Program that pays incentive payments to eligible providers and eligible hospitals that adopt, implement, upgrade, and meaningfully use certified EHR technology in accordance with the provisions of 42 CFR Part 495. Providers and hospitals eligible to participate in the EHR incentive program are identified in 42 CFR Section 495.304. ( )

02. Department Reviewing and Auditing of EHR Incentive Program

Participants. As authorized by 42 CFR Part 495, the Department reviews and audits all professionals and hospitals participating in the EHR incentive program. The Department reviews all practice, documentation, and data related to the EHR technology to determine whether professionals and hospitals participating in the EHR incentive program are eligible and complying with the state and federal rules and regulations. The Department will be reviewing and auditing the EHR program. EHR program participants must meet the following requirements: ( )

a. Patient volume thresholds and calculations, as outlined in 42 CFR Sections 495.304 and 495.306. ( )

b. Eligibility criteria and payment limitations, as outlined in 42 CFR Sections 495.10, 495.304, 495.306, 495.308, and 495.310. ( )

c. Attestations and compliance demonstrations including, at a minimum: ( )

i. Attestations that certified EHR technology has been adopted, implemented, or upgraded; and ( )

ii. Demonstrations of meaningful use, as outlined in 42 CFR Sections 495.6 and 495.8. ( )

d. The payment process and incentive payment amounts, as outlined in 42 CFR Sections 495.310, 495.312, 495.314, and 495.316. ( )

e. Additional issues regarding EHR incentive payments program eligibility, participation, documentation, and compliance as outlined in 42 CFR Part 495. ( )

101. -- 199. (RESERVED).

200. EHR: FEDERALLY INITIATED PROGRAM.

01. Voluntary Federal Program. The EHR Incentive Program is a federal program, using federal funding, and is voluntary for providers. The Department has no obligation to pay incentive payments to the provider once federal funding is exhausted. ( )

02. Idaho Sanctions/Outstanding Debt. ( )

a. To be eligible for incentive payments, providers must be free of both state and federal level sanctions and exclusions as provided in Section 56-209h, Idaho Code, IDAPA 16.05.07, and 42 CFR Part 455. Providers who are on either the Idaho Medicaid Provider Exclusion List (http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ProviderExclusionList.pdf) or on the federal List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov/) are not eligible to participate in the EHR Incentive Program. ( )

b. The Department will reference the Idaho State Sanctions and the Outstanding Debt-Termination Exclusion Lists. Federal level checks with the Office of the Inspector General (OIG) will be conducted through the Idaho Incentive Management System (IIMS) and CMS

interface. ( )

c. Detection for improper payment will be conducted both at the state program level and at the federal level, as referenced in 42 CFR Sections 495.368(a)(1)(i) & (ii). ( )

201. -- 299. (RESERVED).

300. EHR: ADDITIONAL PROVIDER QUALIFICATIONS.

01. Out-of-State Professionals and Hospitals. EHR incentive payments will be made only to Idaho Medicaid providers (professionals with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC that is an Idaho Medicaid provider. ( )

02. Patient Volume Calculation. Encounters for out-of-state Medicaid members (Border States only) may be included in the patient volume calculation only if needed to meet patient volume threshold. Out-of-state encounters must then be included in the numerator and the denominator of the patient volume calculation. ( )

03. Eligible Professionals (EP) Licensure. The Department will consider a provisional license the same as licenses. ( )

300. -- 399. (RESERVED).

400. STATE OPTIONS ELECTIONS UNDER THE EHR INCENTIVE PROGRAM.
In addition to the federal provisions in the ARRA, Section 4201, the Idaho EHR incentive program is governed by federal regulations at 42 CFR Part 495. In compliance with the requirements of federal law, the Department establishes the following State options under the Idaho EHR incentive program: ( )

01. Calculating Patient Volume. For purposes of calculating patient volume as required by 42 CFR Section 495.306, the Department has elected eligible professionals and eligible hospitals to use 42 CFR Section 495.306(c). ( )

02. Patient Volume Methodology. For eligible professionals who use a group proxy patient volume methodology outlined in 42 CFR Section 495.306(h), the EP must see at least one (1) Medicaid or medically underserved patient before he may apply for a Medicaid EHR incentive payment. ( )

03. Hospital Fiscal Year. The twelve (12) month period defined by a hospital for financial reporting purposes that will be used to comply with 42 CFR Section 495.310(g)(1)(i)(B). ( )

04. Determination of Hospital-Based. In accordance with 42 CFR Section 495.4(2)(ii)(B), in order to distinguish "hospital-based eligible professional" from "eligible professional (EP)" during the program year, the Department reviews the quantity and place of services rendered for the CY preceding the program year to which the payment will apply. ( )

401. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.02 - IDAHO TELECOMMUNICATION SERVICE ASSISTANCE PROGRAM RULES

DOCKET NO. 16-0402-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-901, Idaho Code, and 47 CFR 54.405.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule changes for telecommunication service assistance are being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012, Idaho Administrative Bulletin, **Vol. 12-10, pages 427 through 430**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **June 1, 2012**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-901, Idaho Code, and 47 CFR 54.405.

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 October 17, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under changes made by the Federal Communication Commission (FCC), the eligibility level for these services increased from 133% of the Federal Poverty Guidelines (FPG) to 135% of the FPG. These rules are being amended to align with federal regulations for the increase in the FPG, remove and update obsolete language, remove the "Link Up" benefit program that is no longer available in FCC regulations, and add required sections to this rule chapter.

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

The federal regulations governing this program, require that the eligibility level for the telecommunication assistance program be increased and effective on June 1, 2012.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule and was not feasible to

negotiate. The Department is required to align these rules with the federal regulations in 47 CFR 54.405.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner at (208) 334-5656.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0402-1201

000. LEGAL AUTHORITY.
~~*Chapter 9, Title 56,*~~ Section 56-901, Idaho Code, grants legal authority to the Department of Health and Welfare to adopt rules to provide eligible recipients with a reduction in the costs of telecommunication ~~*installation and*~~ service. The program is authorized by the Federal Communication Commission (FCC) under 47 CFR Sections 54.101 through 54.422.
~~*(7-1-99)*~~( )

001. TITLE, ~~*AND*~~ SCOPE, AND PURPOSE.

01. Title. These rules ~~*shall be known as Idaho Department of Health and Welfare Rules,*~~ are cited as IDAPA 16.04.02, "Idaho Telecommunication Service Assistance Program Rules." ( )

02. Scope. These rules contain official requirements governing the program's right to provide eligible recipients with a reduction of costs in telecommunication installation and service.
~~*(7-1-99)*~~( )

03. Purpose. The purpose of these rules is to establish requirements of the Idaho Telecommunication Service Assistance Program (ITSAP) as authorized by Sections 62-610, 56-901, 56-902, 56-903, and 56-904, Idaho Code. ITSAP shall maximize federal "lifeline" contributions to Idaho's low income customers. ( )

002. ~~*(RESERVED)*~~ WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. ( )

003. ADMINISTRATIVE APPEALS.
Contested case appeals ~~*shall be*~~ are governed by Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 300, et seq. ~~*(7-1-99)*~~( )

004. ~~*PURPOSE*~~ INCORPORATION BY REFERENCE.
~~*The purpose of these rules is to establish requirements of the Idaho Telecommunication Assistance Service Program (ITSAP) as authorized by Sections 62-610, 56-901, 56-902, 56-903, and 56-904 of the Idaho Code. ITSAP shall maximize federal "lifeline" and "link-up" contributions to Idaho's low income customers.*~~ No documents are incorporated by reference in this chapter of rule. ~~*(7-1-99)*~~( )

005. OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. ( )

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ( )

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ( )

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ( )

05. Internet Website. The Department's internet website is http://www.healthandwelfare.idaho.gov/. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Disclosure of any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 009. (RESERVED)

0~~05~~10. DEFINITIONS.

01. Assistance Rate Discount. A monthly discount to eligible "lifeline" subscribers ~~*of residential*~~ for basic local ~~*exchange*~~ service ~~*of three dollars and fifty cents ($3.50) or an amount authorized by the Federal Communication Commission, whichever is greater. The discount will*~~

~~*not exceed the rate charged for the grade of residential basic local exchange service subscribed to by each eligible individual. A service installation cost reduction of fifty percent (50%), up to a maximum of thirty dollars ($30), will be granted to eligible "link-up" recipients*~~ under the Idaho Telecommunication Service Assistance Program (ITSAP) authorized in Sections 56-901 through 56-904, and 62-610, Idaho Code. ~~*(7-1-99)*~~( )

02. **Community Action Agency**. A private, non-profit organization serving the low-income population in specified counties of the state which meet the requirements to be designated as a community action agency according to the Community Services Block Grant Act, and has entered into a contract with the Idaho Department of Health and Welfare for the provision of ITSAP services. ( )

0~~2~~3. **Department**. The Idaho Department of Health and Welfare. (3-5-91)

0~~3~~4. **Eligibility Application**. The current Participant Assessment Application form or the Application for Assistance (AFA) form. (7-1-99)

0~~4~~5. **Eligible Basic Local Service**. A single residence telecommunication service at the principal residence of the eligible subscriber/head of household. (7-1-99)

06. **Federal Poverty Guidelines (FPG)**. The poverty guidelines issued annually by the Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services at http://aspe.hhs.gov/poverty. ( )

0~~5~~7. **Head of Household**. The adult member of a household responsible for payment of at least fifty percent (50%) of the cost of the ~~*residential*~~ basic local ~~*exchange*~~ service. ~~*(7-1-99)*~~( )

0~~6~~8. **Household**. A household is either an individual living alone or a group of individuals who are living together ~~*in common living quarters and facilities under such domestic arrangements and circumstances as to create a single establishment*~~ at the same address as one economic unit. A household may include related and unrelated persons. An "economic unit" consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen (18) years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him, both people shall be considered part of the same household. Children under the age of eighteen (18) living with their parents or guardians are considered to be part of the same household as their parents or guardians. ~~*(3-5-91)*~~( )

09. **Income**. Income is the gross amount of money actually received in the recipients household from all sources. ( )

10. **ITSAP**. Idaho Telecommunication Service Assistance Program. ( )

~~*07*~~11. **Lifeline**. ITSAP component that provides a monthly discount rate to eligible subscribers on their ~~*residential*~~ basic local ~~*exchange*~~ service costs. ~~*(7-1-99)*~~( )

~~***08. Link Up**. ITSAP component that provides a discount rate to eligible subscribers*~~

~~*on installation of residential basic local exchange service costs.* *(7-1-99)*~~

~~*09*~~12. **Provider**. The eligible telecommunication carrier providing ~~*residential*~~ basic local ~~*exchange*~~ service to Idaho residents. ~~*(7-1-99)*~~( )

1~~*0*~~3. **Recipient**. A person who is determined eligible for ITSAP. ~~*(7-1-99)*~~( )

1~~*1*~~4. **Subscriber**. ~~*That*~~ A person applying for basic local ~~*exchange*~~ service or, in whose name the ~~*residential*~~ basic local ~~*exchange*~~ service is listed. The subscriber does not need to be the head of the household. ~~*(7-1-99)*~~( )

0~~*0*~~6~~*6*~~11. -- 099. (RESERVED)

100. ASSISTANCE ELIGIBILITY REQUIREMENTS.

01. Head of Household. A ~~*R*~~recipient~~*s*~~ must be the head of the household. ~~*(7-1-99)*~~( )

02. Application. A person must complete an application with the Department or Community Action Agency on behalf of his household, listing all members. The application may be completed by a person other than the head of the household. (7-1-99)

03. Income Limit. The household's gross income must be at or below one hundred and thirty-~~*three*~~five percent (13~~*3*~~5%) of the Federal Poverty ~~*Limit*~~ Guideline (FPG). Households receiving any type of state or federal assistance with income limits at or below one hundred and thirty-~~*three*~~five percent (13~~*3*~~5%) of the ~~*Federal Poverty Limit*~~ FPG are income eligible for ITSAP. ~~*(7-1-99)*~~( )

101. -- 109. (RESERVED)

110. ASSISTANCE DISCOUNT RATE.
An eligible "lifeline" recipient is given a monthly discount for basic local service in the amount of three dollars and fifty cents ($3.50) or an amount authorized by the Federal Communication Commission, whichever is greater. The discount cannot exceed the rate charged for the grade of basic local service subscribed to by eligible recipient. ( )

1~~*0*~~11. -- 399. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

601. -- 99~~*6*~~9. (RESERVED)

~~***996. ADMINISTRATIVE PROVISIONS.***~~
~~*Contested case appeals shall be governed by Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Sections 300, et seq., "Rules Governing Contested Case Proceedings and*~~

~~*Declaratory Rulings."* (12-31-91)~~

~~***997. CONFIDENTIALITY OF RECORDS.***~~
~~*Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records."* (3-5-91)~~

~~***998. (RESERVED)***~~

~~***999. SEVERABILITY.***~~
~~*Idaho Department of Health and Welfare Rules, IDAPA 16.04.02, are severable. If any rule or regulation, or part thereof, or the application of such rule or regulation to any person or circumstance, is declared invalid, that invalidity does not affect the validity of any remaining portion of this chapter.* (3-5-91)~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.10 - RULES GOVERNING THE COMMUNITY SERVICES BLOCK GRANT PROGRAM

DOCKET NO. 16-0410-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and 42 USC Chapter 106.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule aligning the federal poverty level with federal regulations is being adopted as proposed. The complete text of the proposed rule was published in the August 1, 2012, Idaho Administrative Bulletin, **Vol.12-8, pages 57 through 59**.

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

There is no fiscal impact to state general funds for this rulemaking. The Community Services Block Grant program is 100% federally funded.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 4th day of October, 2012.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

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

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and 42 USC Chapter 106.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 15, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended to align them with federal regulations. The eligibility level for the community services block grant program is 125% of the Federal Poverty Guideline (FPG). The eligibility level for these services was temporarily increased to 200% of the FPG under the American Recovery and Reinvestment Act (ARRA) of 2009, and is being reduced, as the increase was not meant to be a permanent increase.

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

These rules need to be aligned with 42 USC Chapter 106 for the Federal Poverty Guideline (FPG) level of 125%. The eligibility level was temporarily increased under ARRA, but has been reduced back to the previous eligibility level.

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

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

There will be no fiscal impact to state general funds for this rulemaking. The Community Services Block Grant program is 100% federally funded.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule and was not feasible to negotiate this rule change. The Department is required to align this program's rules with the federal regulations in 42 USC Chapter 106.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner at (208) 334-5656.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 22, 2012.

DATED this 12th day of July, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0410-1201

010. DEFINITIONS.

01. CSBG. Community Services Block Grant. (3-29-10)

02. Community Action Agency. A private, non-profit organization serving the low-income population in specified counties of the state with which the Idaho Department of Health and Welfare has contracted for the provision of CSBG services. (3-30-01)

03. Department. The Idaho Department of Health and Welfare. (3-30-01)

04. Earned Income. Cash or in-kind payment derived from employment or self-employment. Receipt of a service, benefit, or durable goods instead of wages is in-kind income. Earned income is gross earnings before deductions for taxes or any other purposes. (3-30-01)

05. Eligible Entity. A private, non-profit organization which is a community action agency or a migrant or seasonal farm worker organization receiving CSBG funding before October 27, 1998, or designated by the Department as an eligible entity for an unserved area after October 27, 1998, and which is governed by a tripartite board, as defined in this rule. (3-29-10)

06. Federal Poverty Guidelines (FPG). The poverty guidelines issued annually by

the Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services at http://aspe.hhs.gov/poverty. (3-29-10)

07. HHS. The United States Department of Health and Human Services. (3-29-10)

08. Low-Income and Poor Participants. Those persons receiving or eligible to receive CSBG services who live in households having an income at or below ~~two~~ one hundred twenty-five percent (~~200~~125%) of the federal poverty guidelines. ~~(3-29-10)~~( )

09. Tripartite Board. A board, selected by an eligible entity, which participates in the development, planning, implementation, and evaluation of the community services block grant program, composed as follows: (3-30-01)

a. One-third (1/3) of the board members are elected public officials, currently holding office, or their representatives. Appointed public officials or their representatives will meet this requirement if the number of elected officials available and willing to serve is less than one-third (1/3) of the board membership. (3-30-01)

b. At least one-third (1/3) of the board members are representatives of low-income individuals and families, living in the neighborhoods they serve, chosen by democratic selection procedures. (3-30-01)

c. The remaining board members are officials or members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served. (3-30-01)

10. Unearned Income. Income received from sources other than employment or self-employment, such as Social Security, unemployment insurance, and workers' compensation. (3-30-01)

011. -- 126. (RESERVED)

127. INCOME ELIGIBILITY REQUIREMENTS.
Assistance under this program is limited to participant households with countable income at or below ~~two~~ one hundred twenty-five percent (~~200~~125%) of the federal poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). ~~(3-29-10)~~( )

01. Countable Income. All earned and unearned income is counted in determining eligibility, unless specifically excluded by rule. (3-30-01)

02. Income Not Counted. For eligibility purposes, the following types of income are not counted. (3-30-01)

a. Benefit payments from Medicare Insurance. (3-30-01)

b. State cash assistance payments. (3-30-01)

c. Child care subsidy payments. (3-30-01)

d. Private loans made to the participant or the household. (3-30-01)

e. Assets withdrawn from a personal bank account. (3-30-01)

f. Sale of real property if reinvested within three (3) calender months. (3-30-01)

g. Lump sum payments from an IRA. (3-30-01)

h. Income tax refunds. (3-30-01)

i. Income from capital gains. (3-30-01)

j. Infrequent, irregular or unpredictable income from gifts or lottery winnings of less than one hundred dollars ($100). (3-30-01)

k. Wages or allowances paid to a live-in attendant for care of a disabled person. (3-30-01)

l. Interest posted to a bank account. (3-30-01)

m. Monies for educational purposes from the federal Perkins/National Direct Student Loan program, college work-study programs, state student incentive grants, Supplemental Education Opportunity Grants, Pell, guaranteed student loans, and supplemental grants funded under Title IV, A-2. (3-29-10)

n. Monies from the VA-GI Bill for Education. (3-30-01)

o. Department of Health and Welfare adoption subsidies. (3-30-01)

p. Compensation to volunteers under the Older Americans Act or Foster Grandparent Program, including Green Thumb and Vista volunteers, and the Title V Senior Employment Program. (3-30-01)

q. Payments made by a third party, non-household member for the household, such as for child care, energy assistance, shelter, food and clothing assistance. (3-30-01)

r. Value of food stamps or donated food. (3-30-01)

s. Utility allowance. (3-30-01)

t. Child support income. (3-29-10)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.01 - USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code (Board authority); the Child Abuse Prevention and Treatment Act (CAPTA) (42 USC 5101, et seq.); and Section 9-340B(7), Idaho Code, (from Senate Bill 1255a(2) (2012)).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Disclosure of information regarding child fatalities is required by the Child Abuse Prevention and Treatment Act (CAPTA) under 42 USC 5106a(b)(2)(B)(x). In accordance with CAPTA, this chapter is being amended to specify and clarify the information regarding child fatalities that the Department can disclose. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 57 and 58**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Miren Unsworth at (208) 334-5925.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code (Board authority); the Child Abuse Prevention and Treatment Act (CAPTA) (42 USC 5101, et seq.); and Section 9-340B(7), Idaho Code, (from Senate Bill 1255a(2) (2012)).

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

Tuesday, September 18, 2012 6:00 p.m. (MDT Time)	Wednesday, September 19, 2012 6:00 p.m. (PDT Time)	Thursday, September 20, 2012 6:00 p.m. (MDT Time)
1720 Westgate Dr., Suite D Boise, ID 83704	1250 Ironwood Drive Coeur d'Alene, ID 83814	1070 Hiline, Suite 230 Pocatello, ID 83201

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:

Disclosure of information regarding child fatalities is required by the Child Abuse Prevention and Treatment Act (CAPTA) under 42 USC 5106a(b)(2)(B)(x). In accordance with CAPTA, this chapter is being amended to specify and clarify the information regarding child fatalities that the Department can disclose.

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not deemed feasible as these rule changes are being made to bring this chapter into alignment with the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 111-320).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Miren Unsworth at (208) 334-5925.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0501-1201

210. CHILD PROTECTION.
Unless allowed by these rules or other provision of law, the Department will disclose information from child protection records in its possession upon a court order obtained in compliance with Subsection 075.02 of these rules. Disclosure of Department records under the Child Protective Act is governed by Section 16-1629(6), Idaho Code. Court records of Child Protective Act proceedings are governed by Section 16-1626, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106 and 45 CFR 134.20. Information regarding child fatalities or near fatalities ~~*is required to*~~ may be made public ~~*by 42 USC 5106a(b)(2)(A)(x)*~~. ~~*(4-2-08)*~~( )

01. Child Fatalities. In accordance with 42 USC 5106a(b)(2)(B)(x), the Department will disclose non-identifying summary information to the Statewide Child Fatality Review Team, established by the Governor's Task Force on Children at Risk, regarding child fatalities that were determined to be the result of abuse, neglect, or abandonment. ( )

02. Public Disclosure. The Department has the discretion to disclose child-specific information under this rule when the disclosure is not in conflict with the child's best interests and one (1) or more of the following applies: ( )

a. Identifying information related to child-specific abuse, neglect, or abandonment has been previously published or broadcast through the media; ( )

b. All or part of the child-specific information has been publicly disclosed in a judicial proceeding; or ( )

c. The disclosure of information clarifies actions taken by the Department on a specific case. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-204A, Idaho Code, and Department appropriations under Senate Bill 1414 adopted by the 2012 Legislature.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule for foster care reimbursement is being adopted as proposed. The complete text of the proposed rule was published in the August 1, 2012, Idaho Administrative Bulletin, **Vol. 12-8, pages 60 and 61**.

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

The 2012 Legislature added an ongoing increase to the Department's appropriations budget of $150,000 in state general funds for foster care reimbursements. This funding increase is the only fiscal impact to the state general fund for this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Cameron Gilliland at (208) 334-5702.

DATED this 4th day of October, 2012.

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

e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2012**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant Section 56-202(b) and 56-204A, Idaho Code, and Department appropriations under Senate Bill 1414 adopted by the 2012 Legislature.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 15, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The 2012 Legislature adopted the Department appropriations budget under Senate Bill 1414. The legislative intent language specifically increased the foster family reimbursements in those appropriations. The rules are being amended to reflect this increase in the monthly reimbursement for a child in foster care based on the child's age.

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

These rule are being implemented as a temporary rule to reflect the increase in foster care reimbursements for state fiscal year 2013 that begins on July 1, 2012.

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

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

DHW appropriations in Senate Bill 1414 added an ongoing increase of $150,000 in state

general funds for foster care reimbursements. This funding increase is the only fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is a temporary rule, and the determination was made that it was not feasible to negotiate on this rulemaking.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cameron Gilliland at (208) 334-5702.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 22, 2012.

DATED this 12th day of July, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-1201

483. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
Monthly payments for care provided by family alternate care providers are:

Family Alternate Care Payments - Table 483			
Ages	0-5	6-12	13-18
Monthly Room and Board	$~~274~~301	$~~300~~339	$~~431~~453

~~(5-8-09)~~( )

01. Gifts. An additional thirty dollars ($30) for Christmas gifts and twenty dollars ($20) for birthday gifts will be paid in the appropriate months. (5-8-09)

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (5-8-09)

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the alternate care providers, based upon the Department's determination of the child's needs. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code (Board authority); and the Child Protective Act, Idaho Code, Title 16, Chapter 16.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Foster parents and professionals involved in the ongoing care of children in Idaho's child welfare system continue to report to Department personnel that they are not receiving information necessary to carry out their roles and duties in caring for children in Idaho's child welfare system. In order to remedy this, a rule change is being made to clarify what information the Department can and must provide to foster parents and other professionals involved in the ongoing care of children in Idaho's child welfare system. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 59 through 62**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Miren Unsworth at (208) 334-5925.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
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P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code (Board authority); and the Child Protective Act, Idaho Code, Title 16, Chapter 16.

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

Tuesday, September 18, 2012 6:00 p.m. (MDT Time)	Wednesday, September 19, 2012 6:00 p.m. (PDT Time)	Thursday, September 20, 2012 6:00 p.m. (MDT Time)
1720 Westgate Dr., Suite D Boise, ID 83704	1250 Ironwood Drive Coeur d'Alene, ID 83814	1070 Hiline, Suite 230 Pocatello, ID 83201

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:

Foster parents and professionals involved in the ongoing care of children in Idaho's child welfare system continue to report to Department personnel that they are not receiving information necessary to carry out their roles and duties in caring for children in Idaho's child welfare system. In order to remedy this, a rule change is being made to clarify what information the Department can and must provide to foster parents and other professionals involved in the ongoing care of children in Idaho's child welfare system.

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not deemed feasible as the purpose of this rulemaking is to provide clarification

of the rules and guidance to Department staff regarding the disclosure of information to foster parents and professionals involved in the ongoing care of children in Idaho's child welfare system. It does not change, or in any way relax, the rules for disclosure of information. The actual requirements for the disclosure of information are in IDAPA 16.05.01, "Use and Disclosure of Department Records." Those rules reflect Idaho law on the matter, and are not subject to negotiation as a result of this rulemaking.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Miren Unsworth at (208) 334-5925.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-1202

405. ALTERNATE CARE CASE MANAGEMENT.
Case management must continue while the child is in alternate care and must ensure the following: (3-30-07)

01. Preparation for Placement. Preparing a child for placement in alternate care is the joint responsibility of the child's family, the child (when appropriate), the family services worker, and the alternate care provider. (3-30-07)

02. Information for Alternate Care Provider. The Department and the family must inform the alternate care provider of their roles and responsibilities in meeting the needs of the child including: (3-30-07)

a. Any medical, health and dental needs of the child including the names and address of the child's health and educational providers, a record of the child's immunizations, the child's current medications, the child's known medical problems, and any other pertinent health information concerning the child; (3-18-99)

b. The name of the child's doctor; (3-18-99)

c. The child's current functioning and behaviors; (3-18-99)

d. ~~*The child's history and past experiences and reasons for placement into alternate care*~~ A copy of the child's portion of the service plan including any visitation arrangements; ~~*(3-30-01)*~~( )

e. The case history of the child, including the reason the child came into foster care, the child's legal status, and the permanency goal for the child; ( )

f. A history of the child's previous placements and reasons for placement changes, excluding information that identifies or reveals the location of any previous alternate care providers without their consent; ( )

~~*e*~~**g.** The child's cultural and racial identity; (3-18-99)

~~*f*~~**h.** Any educational, developmental, or special needs of the child; (3-18-99)

~~*g*~~**i.** The child's interest and talents; (3-18-99)

~~*h*~~**j.** The child's attachment to current caretakers; (3-18-99)

~~*i*~~**k.** The individualized and unique needs of the child; (3-18-99)

~~*j*~~**l.** Procedures to follow in case of emergency; and (3-18-99)

~~*k*~~**m.** Any additional information, that may be required by the terms of the contract with the alternate care provider. (3-18-99)

03. Consent for Medical Care. Parent(s) or legal guardian(s) must sign a Departmental form of consent for medical care and keep the family services worker advised of where they can be reached in case of an emergency. Any refusal to give medical consent must be documented in the family case record. (3-30-07)

04. Financial Arrangements. The family services worker must assure that the alternate care provider understands the financial and payment arrangements and that necessary Department forms are completed and submitted. (3-30-07)

05. Contact with Child. The family, the family services worker, and the alternate care provider must establish a schedule for frequent and regular visits with the child by the family and by the family services worker or designee. (5-8-09)

a. Face-to-face contact with a child by the responsible party must occur at least monthly or more frequently depending on the needs of the child or the provider, or both, and the stability of the placement. Face-to-face contact may be made in settings other than where the child resides as long as contact between the responsible party and the child occurs where the child resides a minimum of once every sixty (60) days. (5-8-09)

b. The Department will have strategies in place to detect abuse, neglect, or abandonment of children in alternate care. (5-8-09)

c. Face-to-face contact between the responsible party and a child placed in an in-state group or residential care facility, located a significant distance from the responsible party's office is required a minimum of once every ninety (90) days. Communication by phone between the responsible party and the child must occur at least monthly. (5-8-09)

d. Frequent and regular contact between the child and parents and other family members will be encouraged and facilitated unless it is specifically determined not to be in the best interest of the child. Such contact will be face-to-face if possible, with this contact augmented by telephone calls, written correspondence, pictures, and the use of video and other technology as may be relevant and available. (3-30-07)

e. Children who are in out-of-state placements through the Interstate Compact on the Placement of Children (ICPC) must be contacted face-to-face no less frequently than every six (6) months, by either the responsible party in Idaho, by a representative of the state in which the child is placed, or by a private agency contracted by either. Idaho will request the state in which the child is placed to have face-to-face contact with the child on a monthly basis. If the policy of the state in which the child is placed allows only for face-to-face contact every six (6) months, the responsible party in Idaho will contact the child and the child's caregiver each month by phone to confirm the child's safety and well-being. (4-7-11)

06. Discharge Planning. Planning for discharge from alternate care will be developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (5-8-09)

07. Transition Planning. Planning for discharge from alternate care into a permanent placement will be developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (3-30-07)

08. Financial and Support Services. As part of the discharge planning, Departmental resources will be coordinated to expedite access to Department financial and medical assistance and community support services. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

554. RESPONSE PRIORITIES.

The Department must use the following statewide standards for responding to allegations of abuse, neglect, or abandonment, using the determination of risk to the child as the primary criterion. Any variance from these response standards must be documented in the family's case file with a description of action taken, and must be reviewed and signed by the Child and Family Services Supervisor. (5-8-09)

01. Priority I. The Department must respond immediately if a child is in immediate danger involving a life-threatening or emergency situation. Emergency situations include sexual abuse when a child may have contact with the alleged perpetrator and circumstances indicate a need for immediate response. Law enforcement must be notified and requested to respond or to accompany a family services worker. Every attempt should be made to coordinate the

Department's assessment with law enforcement's investigation. The child must be seen by a Department family services worker, law enforcement, and medical personnel if applicable, immediately unless written regional protocol agreements direct otherwise. All allegations of physical abuse of a child through the age of six (6) or with profound developmental disabilities should be considered under Priority I unless there is reason to believe that the child is not in immediate danger. (3-30-07)

02. Priority II. A child is not in immediate danger but allegations of abuse, including physical or sexual abuse, or serious physical or medical neglect are clearly defined in the referral. Law enforcement must be notified within twenty-four (24) hours. The child must be seen by the family services worker within forty-eight hours (48) of the Department's receipt of the referral. Law enforcement must be notified within twenty-four (24) hours of receipt of all Priority II referrals which involve concerns of abuse, neglect, or abandonment. (5-8-09)

03. Priority III. A child may be in a vulnerable situation because of services needs which, if left unmet, may result in harm, or a child is without parental care for safety, health and well being. The child and parent(s) or legal guardian(s) will be interviewed for substantiation of the facts, and to assure that there is no abuse, neglect, or abandonment by parent(s) or legal guardian(s). A family services worker must respond within three (3) calendar days and the child must be seen by the worker within five (5) calendar days of the Department's receipt of the referral. (5-8-09)

04. Notification of the Person Who Made the Referral. The Department must notify the person who made the child protection referral of the receipt of the referral within five (5) days. (3-30-07)

05. Disclosure of Information to Professionals. The Department has the discretion to disclose, on a need-to-know basis, minimally necessary information to individuals who are professionally involved in the ongoing care of the child who is the subject of a report of abuse, neglect, or abandonment. This includes information that the professional will need to know in order to fulfill his or her role in maintaining the child's safety and well-being. This provision applies to: ( )

a. Physicians, residents on a hospital staff, interns, and nurses; ( )

b. School teachers, school staff, and day care personnel; and ( )

c. Mental health professionals, including psychologists, counselors, marriage and family therapists, and social workers. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.08 - RULES AND MINIMUM STANDARDS FOR DUI EVALUATORS

DOCKET NO. 16-0608-1201 - (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 18-8005(11) and (14), 56-1003 (Director authority), and Section 39-311 (Board authority), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Courts and the Department have agreed it is more effective and efficient to end separate licensing for DUI Evaluators and have DUI evaluations conducted at treatment facilities approved under IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." Therefore, this chapter of rules will be repealed in its entirety. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the Sept. 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 63 and 64**.

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

The repeal of these rules will result in a revenue loss to the Department of approximately $2,500 per year due to the loss of licensing/renewal fees imposed on DUI Evaluators under this chapter.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 18-8005(11) and (14), 56-1003 (Director authority), and Section 39-311 (Board authority), Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING **Thursday, September 13, 2012** **2:00 pm (PDT) -- 3:00 pm (MDT)**
Idaho Department of Health and Welfare, Central Office **Conference Room 3A (3rd floor)** **450 West State Street** **Boise, ID 83702**

VIDEOCONFERENCE LOCATIONS	
Region I Office – Coeur d'Alene **Main Conference Room** **2195 Ironwood Court** **Coeur d'Alene, ID 83814**	**Region II Office – Lewiston** **1st Floor Conference Room** **1118 "F" Street** **Lewiston, ID 83501**
Region III Office – Caldwell **Owyhee Conference Room (Rm. 226)** **3402 Franklin Road** **Caldwell, ID 83605**	**Region IV Office – Boise** **Room 137** **1720 Westgate Drive, Suite A** **Boise, ID 83704**
Region V Office – Twin Falls **Room 116** **823 Harrison** **Twin Falls, ID 83301**	**Region VI Office – Pocatello** **Room 225** **421 Memorial Drive** **Pocatello, ID 83201**

Region VII Office – Idaho Falls
Conference Room 240
150 Shoup Ave.
Idaho Falls, ID 83402

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

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

The Courts and the Department have agreed it is more effective and efficient to end separate licensing for DUI Evaluators and have DUI evaluations conducted at treatment facilities approved under IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs." Therefore, this chapter of rules will be repealed in its entirety.

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

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

The repeal of these rules will result in a revenue loss to the Department of approximately $2,500 per year due to the loss of licensing/renewal fees imposed on DUI Evaluators under this chapter.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking is not feasible as this chapter is simply being repealed at the request of the Courts.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0608-1201

IDAPA 16.06.08 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.12 - RULES GOVERNING THE IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The proposed rules aligned the Idaho Child Care Program rules with other Department eligibility assistance program rules regarding business processes. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the **January 4, 2012, Idaho Administrative Bulletin, Vol. 12-1, pages 126 through 133**.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There is no fiscal impact to state general funds. This program is 100% federally funded.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 4th day of May, 2012.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

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

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 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 January 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department is aligning the Idaho Child Care Program rules with other Department eligibility assistance program rules regarding business processes. These changes streamline and improve the outcomes for individuals in need of assistance by defining excluded income, amending how activity hours are calculated for part-time or full-time assistance, and amending when and how changes are to be reported.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with conferring a benefit for those in need of assistance.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There is no fiscal impact to state general funds. This program is 100% federally funded.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these changes are being made to improve outcomes for individuals in need of assistance and improve efficiencies in the Department's business process.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner at (208) 334-5656.

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 January 25, 2012.

DATED this 23rd day of November, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0612-1201

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH L.
The following definitions and abbreviations apply to this chapter: (4-2-08)

01. AABD. Aid to the Aged, Blind, and Disabled. (4-2-08)

02. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, or child care practices and result in an unnecessary cost to the Idaho Child Care Program, in reimbursement that is not necessary, or that fail to meet professional recognized standards for child care, or result in physical harm, pain, or mental anguish to children. (7-1-09)

03. Child. Any person under age eighteen (18) under the care of a parent, or a person eighteen (18) years of age or older who is claimed on tax returns as a dependent. (4-2-08)

04. Child Care. Care, control, supervision, or maintenance of a child provided for compensation by an individual, other than a parent, for less than twenty-four (24) hours in a day. (4-2-08)

05. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under the Idaho Child Care Program. (7-1-09)

06. Department. The Idaho Department of Health and Welfare or its designee. (7-1-09)

07. Earned Income. Income received by a person as wages, tips, or self-employment income before deductions for taxes or any other purposes. (4-2-08)

08. Employment. A job paying wages or salary at federal or state minimum wage, whichever is applicable, including work paid by commission or in-kind compensation. Full or part-time participation in a VISTA or AmeriCorps program is also employment. (4-2-08)

09. Foster Care. The twenty-four (24) hour substitute care of children provided in a state licensed foster home by persons who may or may not be related to a child. Foster care is provided in lieu of parental care and is arranged through a private or public agency. ~~*(4-2-08)*~~( )

10. Foster Child. A child placed for twenty-four (24) hour substitute care by a private or public agency. (4-2-08)

11. Foster Home. The private home of an individual or family licensed ~~*or approved as meeting the standards for foster care*~~ by the state and providing twenty-four (24) hour substitute care to six (6) or fewer children. ~~*(4-2-08)*~~( )

12. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. (7-1-09)

13. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. (7-1-99)

14. In Loco Parentis. Acting "in loco parentis" means a person who acts in place of a parent, assuming care and custody of a child by a formal or informal agreement with the child's parent. (4-2-08)

15. Intentional Program Violation (IPV). An intentional false or misleading action, omission, or statement made in order to qualify as a provider or recipient in the Idaho Child Care program or to receive program benefits or reimbursement. (7-1-09)

16. Job Training and Education Program. A program designed to provide job training or education. Programs may include high school, junior college, community college, college or university, general equivalency diploma (GED), technical school, and vocational programs. To qualify as a Job Training and Education Program, the program must prepare the trainee for employment. (4-2-08)

17. Knowingly, Known, or With Knowledge. With respect to information or an action about which a person has actual knowledge of the information or action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (7-1-09)

18. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

070. INCOME LIMITS.

~~***01. Maximum Income Limits for ICCP Benefits.***~~ A family's income must be less than the published ~~*2007*~~ Federal Poverty Guidelines for one hundred thirty~~-five~~ percent (13~~5~~0%) of poverty for a family of the same size. The ~~*f*~~Federal ~~*p*~~Poverty ~~*g*~~Guidelines (FPG) are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. ~~*(5-1-11)*~~( )

~~***a.*** *One thousand five hundred forty dollars ($1,540) for a household of two (2);* *(4-2-08)*~~

~~***b.*** *One thousand nine hundred thirty-two dollars ($1,932) for a household of three (3);* *(4-2-08)*~~

~~***c.*** *Two thousand three hundred twenty-three dollars ($2,323) for a household of four (4);* *(4-2-08)*~~

~~***d.*** *Two thousand seven hundred fifteen dollars ($2,715) for a household of five (5);* *(4-2-08)*~~

~~***e.*** *Three thousand one hundred six dollars ($3,106) for a household of six (6);* *(4-2-08)*~~

~~***f.*** *Three thousand four hundred ninety-eight dollars ($3,498) for a household of seven (7);* *(4-2-08)*~~

~~***g.*** *Three thousand eight hundred eighty-nine dollars ($3,889) for a household of eight (8);* *(4-2-08)*~~

~~***h.*** *Four thousand two hundred eighty-one dollars ($4,281) for a household of nine: and* *(4-2-08)*~~

~~***i.*** *Four thousand six hundred seventy-two dollars ($4,672) for a household of 10.* *(4-2-08)*~~

~~***02. Additional Household Member.*** *Three hundred ninety-two dollars ($392) is added to the maximum income limit for each additional family member.* *(4-2-08)*~~

(BREAK IN CONTINUITY OF SECTIONS)

072. EXCLUDED INCOME.
The following sources of income are not counted as family income. (4-2-08)

01. Earned Income of a Dependent Child. Income earned by a dependent child under age eighteen (18) is not counted, unless the child is a parent who is seeking or receiving child care benefits. (4-2-08)

02. Income Received for Person Not Residing With the Family. Income received on behalf of a person who is not living in the home. (4-2-08)

03. Educational Funds. All educational funds including grants, scholarships, an AmeriCorps Education Award, and federal and state work-study income. (4-2-08)

04. Assistance. Assistance to meet a specific need from other organizations and agencies. (4-2-08)

05. Lump Sum Income. Non-recurring or lump sum income is excluded as income if it is used to pay medical bills resulting from accident or injury, or used to pay funeral or burial costs. When lump sum income, minus exclusions, exceeds current income limits for a family of the same size, the family is not eligible to receive child care benefits. The period of ineligibility is computed by dividing the lump sum payment by the family's monthly income limit. In no case will the period of ineligibility exceed twelve (12) months. (4-2-08)

06. Loans. Loans with written, signed repayment agreements. (4-2-08)

07. TAFI and AABD Benefits. ~~*TAFI and AABD benefits.* (4-2-08)~~( )

08. Foster Care Payments. ~~*Foster care payments.* (4-2-08)~~( )

09. AmeriCorps/VISTA Volunteers. Living allowances, wages and stipends paid to AmeriCorps or VISTA volunteers under 42 U.C.S. 5044, P.L. 93-113, Title IV, Section 404(g) are excluded as income. (4-2-08)

10. Income Tax Refunds and Earned Income Tax Credits. Income tax refunds and earned income tax credits are excluded as income. (4-2-08)

11. Travel Reimbursements. Reimbursements from employers for work-related travel. (4-2-08)

12. Tribal Income. Income received from a tribe for any purpose other than direct wages. (4-2-08)

13. Foster Parents' Income. Income of licensed foster parents is excluded when determining eligibility for a foster child. Income is counted when determining eligibility for the foster parent's own child(ren). (4-2-08)

14. Adoption Assistance. Adoption assistance payments are excluded from income. (4-2-08)

15. Child Support Payments. Court-ordered child support payments made by the parent(s) who receive the child care benefits are deducted from income used to determine eligibility. Both the legal obligation to pay child support and the actual amount paid must be verified. (4-2-08)

16. Temporary Census Income. All wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded for a time period not to exceed six (6) months during the regularly scheduled ten-year U.S. Census. (4-7-11)

17. Office of Refugee Resettlement Assistance. ( )

18. Workforce Investment Act Benefits. ( )

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALIFYING ACTIVITIES FOR CHILD CARE BENEFITS.
To be eligible for child care benefits, each parent included in the household must need child care because they are engaged in one (1) of the qualifying activities listed in Subsections 200.01 through 200.05 of this rule. (5-1-11)

01. Employment. The parent is currently employed. (4-2-08)

02. Self-Employment. The parent is currently self-employed in a business that is a sole proprietorship. A sole proprietorship is a business owned by one (1) person. Restrictions apply for self-employment as follows: (5-8-09)

a. For the first six (6) months of self-employment benefits, actual activity hours are used. (5-1-11)

b. After receiving six (6) months of self-employment child care benefits, the number of activity hours will be limited. To calculate the activity hours, the gross monthly self-employment income is divided by the current federal minimum wage. The qualifying activity hours are the lesser of the calculated activity hours or actual activity hours. (5-1-11)

03. Training or Education. The parent is attending an accredited education or training program. The following restrictions apply to training or education activities: (4-2-08)

a. On-line classes cannot be counted as a qualifying activity for child care. (4-2-08)

b. Persons with baccalaureate degrees or who are attending post-baccalaureate classes do not qualify for child care benefits. (4-2-08)

c. More than forty (40) months of post-secondary education has been used as a qualifying activity. (4-2-08)

04. Preventive Services. The parent is receiving preventive services as defined in Section 011 of these rules. The Department will verify the continued need for preventive services at least every three (3) months. (4-2-08)

05. Personal Responsibility Contract (PRC) or Other Negotiated Agreement. The

parent is completing Personal Responsibility Contract (PRC) or other self-sufficiency activities negotiated between the Department and the parent ~~*as described in IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families (TAFI) in Idaho*~~."~~*(4-2-08)*~~( )

201. PROJECTING QUALIFYING ACTIVITY HOURS.

01. Activity Hours. Activity ~~*is*~~ hours are projected for each month to determine if payment is made on a full-time or part-time basis. Past activity hours may be used to project future activity hours if the employer and number of hours worked are the same and are expected to remain the same throughout the certification period. ~~*For students, a new class schedule must be submitted at the beginning of each semester or change in schedule.*~~ Hours for each qualifying activity must be projected individually and converted to a monthly amount. ~~*(5-1-11)*~~( )

01. Weekly Hours. Multiply weekly amounts by four point three (4.3). (5-1-11)

02. Bi-weekly Hours. Multiplying bi-weekly amounts by two point one five (2.15). (5-1-11)

03. Semi-Monthly Hours. Multiplying semi-monthly amounts by two (2). (5-1-11)

04. Monthly Hours. Use the exact monthly hours if it is expected for each month of the certification period. (5-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

502. SLIDING FEE SCHEDULES.
Eligible families, except TAFI families participating in non-employment TAFI activities, must pay part of their child care costs. Providers are responsible for ensuring families pay the determined child care costs and may not waive or defer these costs. (7-1-09)

01. Poverty Rates. Poverty rates will be one hundred thirty ~~*five*~~ percent (13~~5~~0%) of the ~~*2007 f*~~Federal ~~*p*~~Poverty ~~*g*~~Guidelines ~~*published in the Federal Register*~~ (FPG) available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. The monthly rate will be calculated by dividing the yearly rate by twelve (12). ~~*(4-2-08)*~~( )

02. Calculating Family Payment. Family income and activity for the month of the child care will determine the family share of child care costs. The payment made by the Department will be the allowable local market rate or billed costs, whichever is lower, less the co-payment ~~*listed in the following table:*~~. ~~*(5-1-11)*~~( )

~~***03. ICCP Sliding Fee Schedule.***~~

ICCP SLIDING FEE SCHEDULE									
Family Size	2	3	4	5	6	7	8	9	10
Percent Co-pay	MONTHLY INCOME LIMITS								
7%	$499	$599	$699	$799	$899	$1,099	$1,199	$1,399	$1,499
11%	$799	$1,099	$1,299	$1,499	$1,699	$1,999	$2,199	$2,399	$2,599
16%	$949	$1,249	$1,449	$1,699	$1,999	$2,299	$2,549	$2,799	$3,049
21%	$1,099	$1,399	$1,599	$1,899	$2,299	$2,599	$2,899	$3,199	$3,499
26%	$1,165	$1,465	$1,731	$2,031	$2,399	$2,731	$3,031	$3,365	$3,665
31%	$1,231	$1,531	$1,863	$2,163	$2,499	$2,863	$3,163	$3,531	$3,831
36%	$1,299	$1,599	$1,999	$2,299	$2,599	$2,999	$3,299	$3,699	$3,999
41%	$1,308	$1,616	$2,008	$2,316	$2,625	$3,016	$3,325	$3,716	$4,025
46%	$1,317	$1,633	$2,017	$2,333	$2,651	$3,033	$3,351	$3,733	$4,051
51%	$1,326	$1,650	$2,026	$2,350	$2,677	$3,050	$3,377	$3,750	$4,077
56%	$1,335	$1,667	$2,035	$2,367	$2,703	$3,067	$3,403	$3,767	$4,103
61%	$1,344	$1,684	$2,044	$2,384	$2,729	$3,084	$3,429	$3,784	$4,129
66%	$1,356	$1,706	$2,056	$2,406	$2,756	$3,106	$3,456	$3,806	$4,156
71%	$1,386	$1,743	$2,100	$2,457	$2,814	$3,171	$3,528	$3,885	$4,242
76%	$1,416	$1,780	$2,144	$2,508	$2,872	$3,236	$3,600	$3,964	$4,328
81%	$1,446	$1,817	$2,188	$2,559	$2,930	$3,301	$3,672	$4,043	$4,414
86%	$1,476	$1,854	$2,232	$2,610	$2,988	$3,366	$3,744	$4,122	$4,500
91%	$1,506	$1,891	$2,276	$2,661	$3,046	$3,431	$3,816	$4,201	$4,586
96%	$1,540	$1,932	$2,323	$2,715	$3,106	$3,498	$3,889	$4,281	$4,672

(4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

600. CHANGE REPORTING REQUIREMENTS.
A family who applies for or receives child care benefits must report the following permanent changes within ten (10) days of the date the change occurs by the tenth day of the month following the month in which the change occurred. (5-1-11)( )

01. Change in Eligible Activity Hours. (5-1-11)( )

~~02. Change in Rate of Pay.~~ ~~(5-1-11)~~

0~~3~~2. **Change in Your Permanent Address**. (5-1-11)

0~~4~~3. **Change in ~~Number of~~ Household ~~Members~~ Composition**. ~~(5-1-11)~~( )

0~~5~~4. **Change in ~~Unearned~~ Income**. When the household's total gross income exceeds one hundred thirty percent (130%) of the Federal Poverty Guideline (FPG) for the household size. ~~(5-1-11)~~( )

0~~6~~5. **Change in Child Care Provider**. (5-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

602. REDETERMINATION OF ELIGIBILITY FOR CHILD CARE BENEFITS.
The Department must redetermine eligibility for child care benefits at least every six (6) months. Eligibility must be redetermined ~~more often than every six (6) months for the following qualifying activities:~~ ~~(4-2-08)~~

~~01. Preventive Services. The Department must redetermine eligibility~~ every three (3) months for each family in which child care is needed for preventive services. ~~(4-2-08)~~( )

~~02. Education Activities. The Department must redetermine eligibility at the end of each semester or term for parents engaged in educational activities.~~ ~~(4-2-08)~~

(BREAK IN CONTINUITY OF SECTIONS)

810. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.

01. Documentation of Services. Providers must generate documentation at the time of service sufficient to support the reimbursement for child care services. Documentation must be legible and must be retained for a period of three (3) years from the date the child care was provided. Documentation to support child care services includes: (7-1-09)

a. Records of attendance; (7-1-09)

b. Immunization records, conditional admittance form, or exemption form according to IDAPA 16.02.11, "Immunization Requirements for Children Attending Licensed Daycare Facilities in Idaho." ( )

~~b~~**c.** Billing records and receipts; (7-1-09)

~~c~~**d.** Policies regarding sign-in procedures, and others as applicable; and (7-1-09)

~~d~~**e.** Sign-in records, electronic or manual, or the Child and Adult Food Care Program records. (7-1-09)

02. Immediate Access to Records. Providers must grant to the Department and its agents, immediate access to records for review and copying during normal business hours. These records are defined in Subsection 810.01 of this rule. (7-1-09)

03. Copying Records. The Department and its authorized agents may copy any record as defined in Subsection 810.01 of this rule. The Department may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records. (7-1-09)

04. Removal of Records From Provider's Premises.The Department and its authorized agents may remove from the provider's premises copies of any records defined in Subsection 810.01 of this rule. (7-1-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.01 - BEHAVIORAL HEALTH SLIDING FEE SCHEDULES

DOCKET NO. 16-0701-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 16-2433, 19-2524, 20-520(i), 20-511A, and 39-3137 Idaho Code (Director's Authority), and Section 39-309, Idaho Code (Board Authority).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

In 2006, the Legislature passed House Bill 833 that amended the Alcoholism and Intoxication Treatment Act (AITA) to establish the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) effective until July 1, 2011. For a five-year period, starting in SFY 2007, budget decisions regarding substance use disorders treatment were made by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). In accordance with AITA, ICSA sunsetted at the end of SFY 2011 and is no longer in existence. As result, the reference to ICSA in these rules is being removed. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 65 through 69**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 7th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 16-2433, 19-2524, 20-520(i), 20-511A, and 39-3137 Idaho Code (Director's Authority), and Section 39-309, Idaho Code (Board Authority).

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

ORIGINATING LOCATION -- LIVE MEETING **Thursday, September 13, 2012** **2:00 pm (PDT) -- 3:00 pm (MDT)**
Idaho Department of Health and Welfare, Central Office **Conference Room 3A (3rd floor)** **450 West State Street** **Boise, ID 83702**

VIDEOCONFERENCE LOCATIONS	
Region I Office – Coeur d'Alene **Main Conference Room** **2195 Ironwood Court** **Coeur d'Alene, ID 83814**	**Region II Office – Lewiston** **1st Floor Conference Rm.** **1118 "F" Street** **Lewiston, ID 83501**
Region III Office – Caldwell **Owyhee Conference Room (Rm. 226)** **3402 Franklin Road** **Caldwell, ID 83605**	**Region IV Office – Boise** **Room 137** **1720 Westgate Drive, Suite A** **Boise, ID 83704**
Region V Office – Twin Falls **Room 116** **823 Harrison** **Twin Falls, ID 83301**	**Region VI Office – Pocatello** **Room 225** **421 Memorial Drive** **Pocatello, ID 83201**

Region VII Office – Idaho Falls
Conference Room 240
150 Shoup Ave.
Idaho Falls, ID 83402

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

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

In 2006, the Legislature passed House Bill 833 that amended the Alcoholism and Intoxication Treatment Act (AITA) to establish the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) effective until July 1, 2011. For a five-year period, starting in SFY 2007, budget decisions regarding substance use disorders treatment were made by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). In accordance with AITA, ICSA sunsetted at the end of SFY 2011 and is no longer in existence. As result, the reference to ICSA in these rules is being removed.

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

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

No fiscal impact to the state general fund is anticipated due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking is not feasible as this change is being made to align this chapter of rules with the ICSA sunset clause in existing statute.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0701-1201

010. DEFINITIONS.
For the purposes of this chapter, the following definitions apply. (4-9-09)

01. Ability to Pay. The financial capacity that is available to pay for the program services after allowable deductions in relation to gross income and family size exclusive of any liability of third party payor sources. (4-9-09)

02. Adjusted Gross Income. Total family annual income less allowable annual deductions. (4-9-09)

03. Adult. An individual 18 years of age or older. (4-9-09)

04. Adult Mental Health Program. A program administered by the Idaho Department of Health and Welfare to serve severely and persistently mentally ill adults. (4-9-09)

05. Allowable Annual Deductions. In determining the family's ability to pay for behavioral health services, the following are allowable annual deductions: (4-9-09)

a. Court-ordered obligations; (4-9-09)

b. Dependent support; (4-9-09)

c. Child care payments necessary for parental employment; (4-9-09)

d. Medical expenses. (4-9-09)

e. Transportation; (4-9-09)

f. Extraordinary rehabilitative expenses; and (4-9-09)

g. State and federal tax payments, including FICA taxes. (4-9-09)

06. Behavioral Health Services. Services offered by the Department to improve behavioral health issues or alcohol and substance use disorders. (4-9-09)

07. Child. An individual who is under the age of eighteen (18) years. (4-9-09)

08. Children's Mental Health Program. A program as defined in IDAPA 16.07.37, "Children's Mental Health Services," administered by the Idaho Department of Health and Welfare. (4-9-09)

09. Client. The recipient of services. The term "client" is synonymous with the terms:

patient, participant, resident, consumer, or recipient of treatment. (4-9-09)

10. Court-Ordered Obligations. Financial payments which have been ordered by a court of law. (4-9-09)

11. Court-Ordered Recipient. A person receiving behavioral health services under Sections 19-2524, 20-520(i), and 20-511A, Idaho Code. (4-9-09)

12. Department. The Idaho Department of Health and Welfare. (4-9-09)

13. Dependent Support. An individual that is dependent on his family's income for over fifty percent (50%) of his financial support. (4-9-09)

14. Extraordinary Rehabilitative Expenses. Those payments incurred as a result of the disability needs of the person receiving services. They include annual costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received. (4-9-09)

15. Family. A family is an adult, or married adults, or adult(s) with children, living in a common residence. (4-9-09)

16. Family Household. Persons in a family related by blood, marriage, or adoption. Adult siblings who are not claimed as dependents and individuals receiving Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI) are excluded from consideration as a member of the household for income and counting purposes. Income from minor siblings is excluded from household income. The term "family household" is synonymous with the term "family unit." (3-29-10)

17. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found online at http://aspe.hhs.gov/poverty. (4-9-09)

18. Management Service Contractor (MSC). An independent contractor with whom the Department contracts to manage a statewide network of Department-approved facilities and programs to deliver substance use disorders treatment and recovery support services. ( )

1~~8~~9. Parent. The person who, by birth or through adoption, is legally responsible for a child. (4-9-09)

~~19~~20. Recipient. The person receiving services. The term "recipient" is synonymous with the terms: "patient," "participant," "resident," "consumer," or "client." (4-9-09)

2~~0~~1. Sliding Fee Scale. A scale used to determine an individual's financial obligation for services based on Federal Poverty Guidelines and the number of persons in the family household. (4-9-09)

2~~1~~2. Substance Use Disorders Program. A program administered by the Idaho Department of Health and Welfare to serve adolescents and adults with alcohol or substance use disorders. (4-9-09)

2~~2~~3. Third-Party Payer. A payer other than a person receiving services or a responsible party who is legally liable for all or part of the person's care. (4-9-09)

(BREAK IN CONTINUITY OF SECTIONS)

600. CALCULATING INCOME TO APPLY THE SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE DISORDERS SERVICES.

01. Ability to Pay. Charges are based upon the number of dependents and family income. (4-9-09)

a. An ability to pay determination will be made at the time of the voluntary request for services or as soon as possible. (4-9-09)

b. Redetermination of ability to pay will be made at least annually or upon request demonstrating that a substantial material change of circumstances has occurred in family size, income, or allowable deductions. (4-9-09)

c. In determining an individual's ability to pay for services, the Department will deduct annualized amounts for: (4-9-09)

i. Court-ordered obligations; (4-9-09)

ii. Dependent support; (4-9-09)

iii. Child care payments necessary for employment; (4-9-09)

iv. Medical expenses; (4-9-09)

v. Transportation; (4-9-09)

vi. Extraordinary rehabilitative expenses; and (4-9-09)

vii. State and federal tax payments, including FICA. (4-9-09)

d. Information regarding third-party payors and other resources including Medicaid, or private insurance must be identified and developed in order to fully determine the individual's ability to pay and to maximize reimbursement for the cost of services provided. (4-9-09)

e. It is the responsibility of the individual requesting alcohol or substance use disorder services to obtain and provide information not available at the time of the initial financial

interview whenever that information becomes available. (4-9-09)

02. Time of Payment. Payment for services is due thirty (30) days from the date of the billing, unless other arrangements are made. (4-9-09)

03. Charges. Using the sliding fee scale in Section 500 of this rule, an amount will be charged based on family size, resources, income, assets, and allowable deductions, exclusive of third-party liable sources. In no case will the amount charged exceed the costs of the services. (4-9-09)

04. Established Fee. ~~*The maximum hourly fees or flat fees charged for alcohol or substance use disorder services will be established by the Department in collaboration with the Interagency Committee on Substance Abuse Prevention and Treatment and the Board of Health and Welfare.*~~ The maximum hourly fees or flat fees charged for alcohol or substance use disorder services are established by the Department of Health and Welfare. The fees for services are based on the cost for services as set forth in the Department contract with the Management Services Contractor. Current information regarding services and fee charges can be obtained from the Department office as specified in Section 005 of these rules. ~~*(4-9-09)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.17 - ALCOHOL AND SUBSTANCE USE DISORDER SERVICES

DOCKET NO. 16-0717-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-304, 39-311, and 56-1003, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

In 2006, the Legislature passed House Bill 833. HB 833 (2006) amended the Alcoholism and Intoxication Treatment Act (AITA) to establish the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) effective until July 1, 2011. For a five-year period, starting in SFY 2007, budget decisions regarding substance use disorders treatment were made by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). In accordance with AITA, ICSA sunsetted at the end of SFY 2011 and is no longer in existence. As result, the reference to ICSA in these rules is being removed. Also, these rules are being realigned with IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Program," to eliminate existing inconsistencies.

Amendments were made to the pending rule by the Board of Health and Welfare. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 70 through 77**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 15th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-304, 39-311, and 56-1003, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING **Thursday, September 13, 2012** **2:00 pm (PDT) -- 3:00 pm (MDT)**
Idaho Department of Health and Welfare, Central Office **Conference Room 3A (3rd floor)** **450 West State Street** **Boise, ID 83702**

VIDEOCONFERENCE LOCATIONS	
Region I Office – Coeur d'Alene **Main Conference Room** **2195 Ironwood Court** **Coeur d'Alene, ID 83814**	**Region II Office – Lewiston** **1st Floor Conference Rm.** **1118 "F" Street** **Lewiston, ID 83501**
Region III Office – Caldwell **Owyhee Conference Room (Rm. 226)** **3402 Franklin Road** **Caldwell, ID 83605**	**Region IV Office – Boise** **Room 137** **1720 Westgate Drive, Suite A** **Boise, ID 83704**

Region V Office – Twin Falls **Room 116** **823 Harrison** **Twin Falls, ID 83301**	**Region VI Office – Pocatello** **Room 225** **421 Memorial Drive** **Pocatello, ID 83201**
Region VII Office – Idaho Falls **Conference Room 240** **150 Shoup Ave.** **Idaho Falls, ID 83402**	

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

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

In 2006, the Legislature passed House Bill 833. HB 833 (2006) amended the Alcoholism and Intoxication Treatment Act (AITA) to establish the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) effective until July 1, 2011. For a five-year period, starting in SFY 2007, budget decisions regarding substance use disorders treatment were made by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). In accordance with AITA, ICSA sunsetted at the end of SFY 2011 and is no longer in existence. As result, the reference to ICSA in these rules is being removed.

Also, these rules are being realigned with IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Program" to eliminate existing inconsistencies.

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

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

No fiscal impact to the state general fund is anticipated due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking is not feasible as this change is being made to align this chapter of rules with the ICSA sunset clause in existing statute, and with IDAPA 16.07.20, "Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs."

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

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 September 26, 2012.

DATED this 6th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0717-1201

001. TITLE AND SCOPE.

01. Title. The title of these rules is, IDAPA 16.07.17, "Alcohol and Substance Use Disorders Services." (5-8-09)

02. Scope. This chapter defines the scope of voluntary services administered under the Department's Division of Behavioral Health, and describes the eligibility criteria, application requirements, individualized ~~*treatment*~~ service plan requirements, selection of providers, and appeal process under these rules. This chapter is not intended to and does not establish an entitlement for or to receive adult or adolescent alcohol or substance use disorder services, nor is it intended to be applicable to individuals ordered by the court to receive alcohol or substance use disorder services. ~~*(5-8-09)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (5-8-09)

01. Adolescent. An individual between the ages of fourteen (14) and eighteen (18). (5-8-09)

02. Adult. An individual eighteen (18) years or older. (5-8-09)

03. Applicant. An adult or adolescent individual who is seeking alcohol or substance use disorders services through the Department who has completed or had completed on his behalf an application for alcohol or substance use disorder services. (5-8-09)

04. ASAM PPC-2R. Refers to the second edition, revised, manual of the patient

placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine. (5-8-09)

~~***05. Biopsychosocial Assessment.*** *Those procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a treatment plan can be developed.* (5-8-09)~~

05. Assessment and Referral Services. A substance use disorders program provides these services in order to treat, provide services, or refer individuals. An assessment is designed to gather and analyze information regarding a client's current substance use disorder behavioral, social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use *disorder* related treatment or referral. ( )

06. Child. An individual under the age of fourteen (14) years. ~~(5-8-09)~~( )

07. Client. A person receiving treatment for an alcohol or substance use disorder. The term "client" is synonymous with the terms: patient, resident, consumer, or recipient of treatment. (5-8-09)

08. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and alcohol and substance use disorders service needs. (5-8-09)

09. Clinical Necessity. Alcohol or substance use disorder services are deemed clinically necessary when the Department, in the exercise of clinical judgment, would recommend services to an applicant for the purpose of evaluating, diagnosing, or treating alcohol or substance use disorders that are: (5-8-09)

a. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for treating the applicant's alcohol or substance use disorder; and (5-8-09)

b. Not primarily for the convenience of the applicant or service provider and not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's alcohol or substance use disorder. (5-8-09)

10. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians and any other individual deemed appropriate and necessary to ensure that the assessment and subsequent treatment is comprehensive and meets the needs of the proposed client. (5-8-09)

~~***11. Clinically Managed High Intensity Residential Treatment.*** *Frequently referred to as long term residential care or a Therapeutic Community, twenty-four (24) hour intensive residential program designed to treat persons who have significant social and psychological*~~

~~*problems. Individuals who are appropriate for this level of care typically have multiple deficits, which may include criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values.* (5-8-09)~~

1~~2~~1. **Clinically Managed Low-Intensity Residential Treatment**. Is a program that offers at least five (5) hours per week of outpatient or intensive outpatient treatment services along with a structured recovery environment, staffed twenty-four (24) hours per day, which provides sufficient stability to prevent or minimize relapse or continued use. This level of care is also known as a Halfway House. (5-8-09)

1~~3~~2. **Clinically Managed Medium-Intensity Residential Treatment**. Frequently referred to as residential care, programs provide a structured, twenty-four (24) hour intensive residential program for clients who require treatment services in a highly structured setting. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence. Community reintegration of residents in this level of care requires case management activities directed toward networking clients into community-based recovery support services such as housing, vocational services or transportation assistance so that the client is able to attend mutual/self-help meetings or vocational activities after discharge. (5-8-09)

13. **Comprehensive Assessment**. Those procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a service plan can be developed. ( )

14. **Contracted Intermediary**. A third party contractor of the Department who handles direct contracting with network providers for treatment services to include network management, claims payment, data gathering per Federal and State requirements and census management. (5-8-09)

15. **Department**. The Department of Health and Welfare or a person authorized to act on behalf of the Department. (5-8-09)

16. **Early Intervention Services**. ~~*Early intervention s*~~Services that are designed to explore and address ~~*an adolescent's*~~ problems or risk factors that appear to be related to substance use~~*, i.e., alcohol, tobacco, or other drugs, and to assist the adolescent in recognizing the harmful consequences of substance use. Early intervention services are intended to be a combination of prevention and treatment services for at-risk youth*~~. ~~*(5-8-09)*~~( )

17. **Emergency**. An emergency exists if an adult or adolescent individual is gravely disabled due to mental illness or substance abuse or dependence or there is a substantial risk that physical harm will be inflicted by the proposed client: (5-8-09)

a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (5-8-09)

b. Upon another person as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm. (5-8-09)

18. **Federal Poverty Guidelines**. Guidelines issued annually by the Federal

Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/. (5-8-09)

19. Gravely Disabled. An adult or adolescent who, as a result of mental illness or substance abuse or dependence, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, or essential medical care, or shelter or safety. (5-8-09)

20. Individualized ~~*Treatment*~~ Service Plan. A written action plan based on an intake eligibility screening and full clinical assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions. ~~*(5-8-09)*~~( )

21. Intake Eligibility Screening. The collection of data, analysis, and review, which the Department, or its designee, uses to screen and determine whether an applicant is eligible for adult or adolescent alcohol or substance use disorder services available through the Department. (5-8-09)

22. Intensive Outpatient Services. An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. (5-8-09)

23. Medically Monitored Detoxification. Means medically supervised twenty-four (24) hour care for patients who require hospitalization for treatment of acute alcohol intoxication or withdrawal, from one (1) or more other substances of abuse, and other medical conditions which together warrant treatment in this type of setting. Length of stay varies depending on the severity of the disease and withdrawal symptoms. ~~*(5-8-09)*~~( )

24. Medically Monitored Inpatient Treatment. Medically supervised twenty-four (24) hour care for patients requiring hospitalization and treatment services. Medically monitored inpatient treatment provides treatment services and access to full range of services offered by the hospital. ( )

2~~4~~5. Network Treatment Provider. A treatment provider who has facility approval through the Department and is contracted with the Department's Management Service Contractor. A list of network providers can be found at the Department's website given in Section 005 of these rules. The list is also available by calling these telephone numbers: 1 (800) 922-3406; or dialing 211. (5-8-09)

26. Opioid Replacement Outpatient Services. This service is specifically offered to a client who has opioids as his substance use disorder. Services are offered under the guidelines of a federally accredited program. ( )

2~~5~~7. Outpatient Services. An organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for alcohol and substance use disorders. (5-8-09)

2~~6~~8. **Priority Population**. Priority populations are populations who receive services ahead of other persons and are determined yearly by the Department based on ~~F~~federal regulations ~~*and input from the Interagency Committee on Substance Abuse Prevention and Treatment*~~. A current list of the priority population is available from the Department.
~~*(5-8-09)*~~( )

2~~7~~9. **Recovery Support Services**. These services include: safe and sober housing that is staffed; transportation; child care; family education; life skills education; marriage education; drug testing; peer to peer mentoring; and case management. (5-8-09)

~~*28*~~30. **Residential Social Detoxification**. Means a medically supported twenty-four (24) hour, social rehabilitation residential program which provides physical care, education, and counseling as appropriate for the client's health and safety during his process of physical withdrawal from acute alcohol intoxication or withdrawal, or from one or more other substances of abuse. Social detoxification provides access into care and treatment of alcohol or substance use disorders through monitored withdrawal, evaluation of present or potential alcohol or substance dependency and other physical ailments, and intervention into the progression of the disease through timely utilization or resources. Length of stay in a social detoxification program varies from three (3) to seven (7) days depending on the severity of the disease and withdrawal symptoms. (5-8-09)

~~*29*~~31. **Sliding Fee Scale**. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." (5-8-09)

3~~0~~2. **Substance Dependence**. Substance dependence is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been cause or exacerbated by such use as defined in the DSM-IV-TR. (5-8-09)

3~~1~~3. **Substance-Related Disorders**. Substance-related disorders include disorders related to the taking of alcohol or another drug of abuse, to the side effects of a medication and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR. (5-8-09)

3~~2~~4. **Substance Use Disorder**. Includes Substance Dependence and Substance Abuse, according to the DSM-IV-TR. Substance Use Disorders are one (1) of two (2) subgroups of the broader diagnostic category of Substance-Related Disorders. (5-8-09)

3~~3~~5. **Substantial Material Change in Circumstances**. A substantial and material change in circumstances which renders the Department's decision denying alcohol and substance

use disorders services arbitrary and capricious. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

102. ELIGIBILITY DETERMINATION.

01. Determination of Eligibility for Alcohol and Substance Use Disorders Services. The total number of adults and adolescents who are eligible for alcohol or substance use disorders services through the Department will be established by the Department~~, in consultation with the Idaho Interagency Committee on Substance Abuse Prevention and Treatment~~. The Department may~~, in consultation with the Idaho Interagency Committee on Substance Abuse Prevention and Treatment,~~ limit or prioritize adult and adolescent alcohol or substance use disorder services, define eligibility criteria, and establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. ~~(5-8-09)~~( )

02. Eligibility Requirements. To be eligible for alcohol and substance use disorders services through a voluntary application to the Department, the applicant must: (5-8-09)

a. Be an adult or adolescent with family income at or below two hundred percent (200%)of federal poverty guidelines; (5-8-09)

b. Be a resident of the state of Idaho; (5-8-09)

c. Be a member of the priority population; (5-8-09)

d. Meet diagnostic criteria for substance dependence, or a substance-related disorder as described in the DSM-IV-TR; and (5-8-09)

e. Meet specifications in each of the ASAM PPC-2R dimensions required for the recommended level of care. (5-8-09)

03. Admission to Treatment Program Requirements. In order to be admitted into an adult or adolescent alcohol or substance use disorders treatment program, there must be clinical evidence that provides a reasonable expectation that the applicant will benefit from the alcohol or substance use disorder services. (5-8-09)

04. Ineligible Conditions. An applicant who has epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, mental illness, or who is aged, is not eligible for alcohol and substance use disorders services, unless, in addition to such condition, they meet primary diagnostic criteria for substance abuse, substance dependence, or a substance related disorder as described in the DSM-IV-TR and the specification in each of the ASAM PPC-2R dimensions required for the recommended level of care. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

200. INDIVIDUALIZED ~~*TREATMENT*~~ SERVICE PLAN, SELECTION OF SERVICE PROVIDERS AND AVAILABLE TREATMENT SERVICES.
The Department's contracted ~~*treatment*~~ provider will prepare for every client an individualized ~~*treatment*~~ service plan that addresses the alcohol or substance disorders health affects on the client's major life areas. The ~~*treatment*~~ service plan will be based on a ~~*biopsychosocial*~~ comprehensive assessment ~~*of the client's alcohol or substance use disorders treatment needs*~~.
~~*(5-8-09)*~~( )

01. Individualized ~~*Treatment*~~ Service Plan. ~~*Overall*~~ The responsibility for development and implementation of the plan will be assigned to a qualified ~~*professional*~~ staff member ~~*within a Department contracted network treatment provider program*~~. A ~~*detailed individualized treatment*~~ service plan will be developed within ~~*fourteen (14) days following the Department's determination that an applicant is eligible for alcohol and substance use disorders services through the Department*~~ seventy-two (72) hours following admission to an inpatient or residential facility and within thirty (30) days of the completion or receipt of a state-approved assessment in an outpatient setting. The individualized ~~*treatment*~~ service plan will include the following:
~~*(5-8-09)*~~( )

a. The services deemed clinically necessary to ~~*meet*~~ facilitate the client's alcohol and substance use disorders ~~*needs*~~ recovery;
~~*(5-8-09)*~~( )

b. Referrals for needed ~~*adjunct services that the alcohol and substance use disorders treatment program does not provide*~~ services not provided by the program, including referrals for recovery support services;
~~*(5-8-09)*~~( )

c. Goals ~~*that the client must*~~ to achieve a recovery-oriented lifestyle; ~~*(5-8-09)*~~( )

d. ~~*Specific o*~~Objectives that relate to the goals, written in measurable terms, with targeted expected achievement dates;
~~*(5-8-09)*~~( )

e. Service ~~*F*~~Frequency ~~*of services*~~;
~~*(5-8-09)*~~( )

f. ~~*Specific c*~~Criteria to be met for discharge from ~~*treatment*~~ services; ~~*and*~~
~~*(5-8-09)*~~( )

g. A plan for services to be provided after discharge; ( )

~~*g*~~h. A ~~*specific*~~ plan for including the family or ~~*significant*~~ others~~.~~ social supports; and
~~*(5-8-09)*~~( )

i. Service plan goals and objectives that reflect the service needs identified on the assessment. ( )

02. Selection of Providers. The client can choose from among the array of substance use disorders treatment providers approved to provide services. The services must be within the

recommended level of care according to ASAM PPC-2R and based on needs identified in the ~~*biopsychosocial*~~ comprehensive assessment and resultant individualized ~~*treatment*~~ service plan. The client does not have the option of choosing his treatment provider if he is within the criminal justice system and specific providers have been identified for the client. ~~*(5-8-09)*~~( )

03. Treatment Services Available. Available alcohol or substance use disorders treatment services, as defined in Section 010 of these rules, include: (5-8-09)

a. ~~*Early intervention*~~ Assessment and Referral services; ~~*(5-8-09)*~~( )

b. ~~*Outpatient services*~~ Residential social detoxification; ~~*(5-8-09)*~~( )

c. ~~*Intensive outpatient services*~~ Medically monitored inpatient treatment; ~~*(5-8-09)*~~( )

d. ~~*Residential social detoxification*~~ Medically monitored detoxification; ~~*(5-8-09)*~~( )

e. ~~*Medical detoxification*~~ Clinically managed medium-intensity residential treatment; ~~*(5-8-09)*~~( )

f. Clinically managed low-intensity residential treatment; (5-8-09)

g. ~~*Clinically managed medium intensity residential treatment*~~ Level I – Outpatient, and Level II.I Intensive Outpatient; ~~*and*~~ ~~*(5-8-09)*~~( )

h. ~~*Clinically managed high intensity residential treatment.*~~ Opioid treatment program; ~~*(5-8-09)*~~( )

i. Recovery support services; and ( )

j. Early intervention services. ( )

04. Treatment Services Not Available. Alcohol or substance use disorder treatment services, do not include: (5-8-09)

a. Experimental or investigational procedures; (5-8-09)

b. Technologies and related services; (5-8-09)

c. Electroconvulsive therapy; (5-8-09)

d. Treatment or services for epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, aged or the infirm; or (5-8-09)

e. Any other services which are primarily recreational or diversional in nature. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.20 - ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT AND RECOVERY SUPPORT SERVICES FACILITIES AND PROGRAMS

DOCKET NO. 16-0720-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice, the pending rule will become final and effective on **July 1, 2013**, after review by the legislature, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code, Alcoholism and Intoxication Treatment Act (AITA), and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Department is making revisions to this chapter of rule to accommodate the current substance use disorders treatment environment and integration with Mental Health. Revisions are also needed to align the treatment system with changes in health care standards and move to a recovery oriented system of care. In addition, provider requirements need to be streamlined to allow the provider system to function in a more efficient manner. Finally, the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) established by the 2006 Legislature is no longer in existence and references to ICSA in these rules are being removed.

Amendments were made to the pending rule by the Board of Health and Welfare. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 5, 2012, Idaho Administrative Bulletin, **Vol. 12-9, pages 78 through 134**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 15th day of November, 2012.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500; fax: (208) 334-6558
e-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code (Alcoholism and Intoxication Treatment Act (AITA)) (Board authority), and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code (Director authority).

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

ORIGINATING LOCATION -- LIVE MEETING **Thursday, September 13, 2012** **2:00 pm (PDT) -- 3:00 pm (MDT)**
Idaho Department of Health and Welfare, Central Office **Conference Room 3A (3rd floor)** **450 West State Street** **Boise, ID 83702**

VIDEOCONFERENCE LOCATIONS	
Region I Office – Coeur d'Alene **Main Conference Room** **2195 Ironwood Court** **Coeur d'Alene, ID 83814**	**Region II Office – Lewiston** **1st Floor Conference Rm.** **1118 "F" Street** **Lewiston, ID 83501**
Region III Office – Caldwell **Owyhee Conference Room (Rm. 226)** **3402 Franklin Road** **Caldwell, ID 83605**	**Region IV Office – Boise** **Room 137** **1720 Westgate Drive, Suite A** **Boise, ID 83704**

Region V Office – Twin Falls **Room 116** **823 Harrison** **Twin Falls, ID 83301**	**Region VI Office – Pocatello** **Room 225** **421 Memorial Drive** **Pocatello, ID 83201**
Region VII Office – Idaho Falls **Conference Room 240** **150 Shoup Ave.** **Idaho Falls, ID 83402**	

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

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

In 2006, the Legislature passed House Bill 833. HB 833 amended the Alcoholism and Intoxication Treatment Act (AITA) to establish the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA) effective until July 1, 2011. For a five-year period, starting in SFY 2007, budget decisions regarding substance use disorders treatment were made by the Interagency Committee on Substance Abuse Prevention and Treatment (ICSA). In accordance with AITA, ICSA sunsetted at the end of SFY 2011 and is no longer in existence. As result, the reference to ICSA in these rules needs to be removed.

Also, some rule revisions are needed to accommodate the current substance use disorder treatment environment. Treatment providers must now respond to four referral sources, each of which have different treatment and reporting requirements. Finally, provider requirements need to be streamlined to allow the provider system to function in a more efficient manner.

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

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

No fiscal impact to the state general fund is anticipated due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking is not feasible as this change is being made to align this chapter of rules with the ICSA sunset clause in existing statute, and with current practice in substance use disorder treatment.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

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 September 26, 2012.

DATED this 10th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0720-1201

002. WRITTEN INTERPRETATIONS.

~~*In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department has a Minimum Case Management Standards Manual which contains forms, policies, procedures, and interpretations of these rules for the development and provision of case management services, or to the documentation of compliance with the rules of this chapter. These documents are available for public inspection as described in Sections 005 of these rules. The standards are also available by accessing the Department's website at http://www.healthandwelfare.idaho.gov, and clicking on the links under "RSS Case Management." (http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RecoverySupportServices/tabid/381/Default.aspx)*~~ There are no written interpretations of these rules. ~~*(5-1-10)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. ~~*All owners, operators, employees, transfers, reinstated former employees, student interns, contractors and volunteers hired or contracted with after May 1, 2010, who provide direct care or service or have direct client access, must comply with the provisions of IDAPA 16.05.06 "Criminal History and Background Checks."*~~ Each alcohol and substance use disorders treatment and recovery support services program must comply with the provisions of IDAPA 16.05.06, "Criminal History and Background Checks." Criminal history and background checks must be completed on the owner, employees, applicants, transfers, reinstated former employees, trainees, contractors, and volunteers who provide care or services, or have access to clients in an alcohol and substance use disorders treatment and recovery support services program. The applicant is responsible for the cost of the criminal history and background check except where otherwise provided by Department rules.
~~*(5-1-10)*~~( )

02. Availability to Work. An individual listed in Subsection 009.01 of these rules is

available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. (5-1-10)

010. DEFINITIONS - A THROUGH C.
For the purposes of these rules, the following terms are used. (5-1-10)

01. Access. A client's ability to obtain alcohol or substance use disorder treatment or services that he is seeking. (5-1-10)

~~***02. Active Client**. A client who receives services from an approved alcohol and substance use disorders treatment or recovery support services program, who has had face-to-face contact with a program's qualified substance use disorders professional within the immediately preceding thirty (30) calendar days.* (5-1-10)~~

02. Adolescent. An individual between the ages of fourteen (14) and eighteen (18) years. ~~(5-1-10)~~( )

03. Admission. The point in an applicant's relationship with a state-approved substance use disorders treatment program or recovery support services program when the screening and assessment process has been completed and the applicant has been found eligible by the Department to receive the services of the program. (5-1-10)

04. Adult. An individual eighteen (18) years of age or older. (5-1-10)

05. Adjunct Services. Those clinical and non-clinical services provided outside of an approved alcohol and substance use disorders treatment or recovery support services program that support client recovery. Adjunct services may include: Women, Infant and Children (WIC), welfare, mental health services, and medical services. (5-1-10)

06. Advocacy. The act of pleading for, supporting, or recommending services, supports, treatment, or opportunities for a client. For example, a case manager advocates for the unmet needs of the client and encourages independence. Advocacy, as part of case management, can be done with or for a client. (5-1-10)

07. Alcohol and Drug Testing. The collection and initial screening of urine, hair, or oral fluid samples for screening and detecting alcohol and substance use. (5-1-10)

08. Applicant. A person, firm, partnership, association, corporation, agency, or organization which has filed an application with the Department to become an approved alcohol and substance use disorders treatment or recovery support services program under these rules. (5-1-10)

~~1~~09. Appropriate. A term used to indicate that a particular procedure, treatment, test,

or service is suitable or compatible in quantity, and provided in the best setting to meet the client's needs. (5-1-10)

1~~1~~0. Approved Private Treatment Facility. An alcohol and substance use disorders treatment program or recovery support services program meeting the standards prescribed in Section 39-305(1), Idaho Code, and approved under the provisions of Section 39-305(3), Idaho Code, and these rules. The term "facility" is synonymous with the term "program." (5-1-10)

1~~2~~1. Approved Public Treatment Facility. An alcohol and substance use disorders treatment program or recovery support services program operating under the Alcoholism and Intoxication Treatment Act (Title 39, Chapter 3, Idaho Code) through a contract with the Department and meeting the standards prescribed in Section 39-305(1), Idaho Code, and approved pursuant to Section 39-305(3), Idaho Code and these rules. The term "facility" is synonymous with the term "program." (5-1-10)

1~~3~~2. ASAM PPC-2R. Refers to the manual containing the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine (ASAM) as incorporated by reference in Section 004 of these rules. (5-1-10)

1~~4~~3. Assessment and Referral Services. A substance use disorders program provides these services in order to treat, provide services, or refer individuals. An assessment is designed to gather and analyze information regarding a client's current substance use disorder behavioral, social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance abuse related treatment or referral. (5-1-10)

1~~5~~4. Behavioral Health Services. Services offered by the Department to treat behavioral health issues or alcohol and substance use disorders. (5-1-10)

~~***16. Biopsychosocial Assessment**. Those procedures by which a qualified substance use disorders professional evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a treatment plan can be developed.* (5-1-10)~~

1~~7~~5. CARF. The Commission on Accreditation of Rehabilitation Facilities. (5-1-10)

1~~8~~6. Case Management. The administration and evaluation of an array of services that may include assessment of client and client family needs, service planning, linkage to other services, client advocacy, monitoring service provision, and coordination of services. (5-1-10)

17. Case Management Assessment. A determination of a client's strengths and needs including medical, psychosocial, educational, financial, and other services that includes a description of the client's strengths, informal support system, and environmental factors relative to his or her recovery. ( )

18. Case Manager. An individual qualified to provide case management services under Section 745 of these rules. ( )

~~***19. Case Management Planning**. The planning process where the case manager and*~~

~~*client, parent, guardian, spouse, or significant other, as applicable, define goals, strategies to achieve these goals, responsibilities for action, and time frames for action. It also includes community reintegration planning, and discharge planning to terminate case management services when case management is no longer required by the client, goals have been met, the client no longer wishes to participate in case management, or the client is no longer eligible for services.* *(5-1-10)*~~

~~*20*~~19. **Case Management Supervision**. Case management supervision includes planning, directing, monitoring, and evaluating the work of a case manager by an individual who meets the qualifications of a case manager supervisor. A clinical supervisor of a treatment agency may fulfill this role and may incorporate case management supervision into clinical supervision activities. (5-1-10)

2~~*1*~~0. **Case Management Supervisor**. The program staff member responsible for oversight of all case management aspects of the case management services provided. A clinical supervisor of a treatment agency may also fulfill this role. (5-1-10)

2~~*2*~~1. **Certificate of Approval**. A certificate issued by the Department under Section 145 of these rules to an alcohol and substance use disorders treatment or recovery support services program which the Department deems to be in compliance with these rules. (5-1-10)

2~~*3*~~2. **Certified Home Inspection**. An inspection of a residential dwelling conducted by a registered, licensed, or certified home inspector to determine the quality, safety, and overall condition of the dwelling. (5-1-10)

2~~*4*~~3. **Child**. An individual under the age of fourteen (14) years. ~~*(5-1-10)*~~( )

2~~*5*~~4. **Client**. A person receiving treatment for an alcohol or a substance use disorder or receiving recovery support services. The term "client" is synonymous with the terms "patient," "resident," "consumer," "participant," or "recipient of treatment." (5-1-10)

2~~*6*~~5. **Client Record**. All documentation of individual client treatment and related services. (5-1-10)

~~***27. Clinical Case Management**. Clinical case management is a service that integrates mental health and substance use disorders clinical expertise with case management skills to implement comprehensive interventions that address the overall maintenance of the client's physical and social environment. Clinical case management includes: engagement of the client, assessment, planning, treatment, linkage with resources, consultation with families, collaboration with psychiatrists, client education, and crisis intervention.* *(5-1-10)*~~

2~~*8*~~6. **Clinical Judgment**. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and alcohol and substance use disorders service needs. (5-1-10)

2~~*9*~~7. **Clinical Supervision**. ~~*Clinical supervision includes planning, directing,*~~

~~monitoring, and evaluating the clinical work of another staff person by a Department-qualified clinical supervisor.~~ Supervision centered on the clinician's knowledge, skills and attitudes and includes: evaluation of competencies, observation of skills, mentoring, planning and monitoring the work of another clinical staff person by a qualified clinical supervisor. ~~(5-1-10)~~( )

~~30~~28. **Clinical Supervisor**. ~~The program staff member~~ A professional qualified under Section 216 of these rules who is responsible for oversight of all clinical aspects of the treatment services provided. ~~(5-1-10)~~( )

~~31. Clinically Managed High-Intensity Residential Treatment. A program that offers intensive residential treatment services, staffed twenty-four (24) hours per day, seven (7) days a week, which is designed to treat persons who have significant social and psychological problems. Individuals who are appropriate for this level of care typically have multiple deficits, which may include criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. This level of care is also known as long-term residential care or a Therapeutic Community.~~ ~~(5-1-10)~~

~~3~~29. **Clinically Managed Low-Intensity Residential Treatment**. A program that offers at least five (5) hours per week of outpatient or intensive outpatient treatment services along with a structured residential recovery environment, staffed twenty-four (24) hours per day, seven (7) days a week, which provides sufficient stability to prevent or minimize relapse or continued use. This level of care is also known as a Halfway House. (5-1-10)

~~3~~30. **Clinically Managed Medium-Intensity Residential Treatment**. A program that offers structured residential treatment services, staffed twenty-four (24) hours per day, seven (7) days a week, which provides intensive residential program for clients who require treatment services in a highly-structured setting. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence. Community reintegration of residents in this level of care requires case management activities directed toward networking clients into community-based recovery support services such as housing, vocational services, or transportation assistance so that the client is able to attend mutual self-help meetings or vocational activities after discharge. This level of care is also known as residential care. (5-1-10)

3~~4~~1. **College of Professional Psychology**. Professional certification entity of the American Psychological Association Practice Organization. (5-1-10)

3~~5~~2. **Competencies**. Competencies are the knowledge, skills, and attitudes required for the members of the alcohol and substance use disorders clinical staff as a prerequisite to proficiency in the professional treatment of alcohol and substance use disorders. The model of competencies is determined by the Department. (5-1-10)

3~~6~~3. **Compliance**. Demonstration that these rules, policies and procedures, and applicable federal and state statutes and regulations are observed. Compliance is determined by the Department. (5-1-10)

34. **Comprehensive Assessment**. Procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a service plan can be developed. ( )

3~~7~~5. Comprehensive Case Management Service Plan. A written comprehensive service plan based on a current assessment as described in Section 370 of these rules, that addresses the medical, psychosocial, legal, educational, and financial needs of the client. The comprehensive service plan provides for the coordination of services across multiple need dimensions. (5-1-10)

~~***38. Continuing Care**. Care that supports a client's progress, monitors his condition, and can respond to a return to substance use or a return of symptoms of mental disorder. It is both a process of post-treatment monitoring and a form of treatment itself. (5-1-10)~~

3~~9~~6. Contract. A formal agreement with any organization, agency, or individual specifying the services, personnel, products or space to be provided by, to, or on behalf of the program and the consideration to be expended in exchange. (5-1-10)

~~40~~37. Contractor. A person or company that performs work, provides supplies, or delivers services for another under a written agreement. (5-1-10)

~~41~~38. Contracted Intermediary. A third party contractor of the Department who handles direct contracting with network providers for alcohol and substance use disorders treatment and recovery support services. Direct services may include network management, claims payment, data gathering per federal and state requirements, and census management. (5-1-10)

~~42~~39. Co-Occurring Capable. The ability of a treatment provider to recognize the signs and symptoms of a co-occurring disorder and make a referral to an appropriate mental health facility. (5-1-10)

4~~3~~0. Co-Occurring Disorders (COD). The co-occurring diagnoses of mental health and substance use disorders. (5-1-10)

41. Correspondence. Written or digital communication concerning the client or client's recovery. Correspondence may include: letters, emails, text messages, voicemails, or notes. ( )

4~~4~~2. Criminogenic Need. A client attribute shown by research to be correlated with criminal behavior and to be an appropriate target for treatment intervention. (5-1-10)

011. DEFINITIONS - D THROUGH H.
For the purposes of these rules, the following terms are used. (5-1-10)

01. Department. The Idaho Department of Health and Welfare. (5-1-10)

02. Detoxification Services. Services necessary to monitor individuals who are undergoing the systematic reduction of a toxic agent from the body during withdrawal. (5-1-10)

03. Direct Client Access. Direct client access means an employee, contractor, or volunteer who has accessibility to a client. (5-1-10)

04. Director. The Director of the Department of Health and Welfare or his designee. (5-1-10)

05. Discharge. The point at which the client's active involvement in treatment or recovery support services is terminated and the program no longer maintains active responsibility for the care of the client. (5-1-10)

~~***06. Discharge Plan**. The plan developed jointly by the qualified substance use disorders professional and the client that provides the client with the resources needed to support his recovery. (5-1-10)~~

0~~7~~6. Discharge Summary. A document written by the client's provider upon discharge from treatment and contains a summary of the following: (5-1-10)

~~***a.** Assessment of client problems at admission; (5-1-10)~~

~~***b.** Expected treatment outcomes; (5-1-10)~~

~~***c.** Treatment plans and strategies; (5-1-10)~~

~~***d**~~**a.** Client status at discharge; (5-1-10)

~~***e**~~**b.** Treatment progress; (5-1-10)

~~***f**~~**c.** Summaries of ~~*continuing care plans*~~ services to be provided after discharge; and ~~(5-1-10)~~( )

~~***g**~~**d.** Referrals for further treatment. (5-1-10)

~~***08. Drug Court Outpatient Treatment Program**. A Department-approved program for the treatment of alcohol and substance use disorders for individuals under the jurisdiction of a local drug court. (5-1-10)~~

~~***09. Drug Court Team**. Individuals who collectively plan and evaluate services for drug court participants and determine participant compliance, progress, sanctions, movement from one (1) treatment phase to another, and continuation or termination of drug court treatment. (5-1-10)~~

~~1~~07. Early Intervention Services. Services that are designed to explore and address problems or risk factors that appear to be related to substance use. ~~(5-1-10)~~( )

~~11~~08. Education. Strategies that teach people critical information about alcohol and other drugs and the physical, emotional, and social consequences of their use. (5-1-10)

~~12~~09. Executive Director. The individual who is responsible for the overall management of the program or facility. The executive director is appointed by the governing body to act on its behalf. The term "executive director" is synonymous with the terms "administrator,"

"director," "superintendent," "president," "vice-president," and "executive vice-president." (5-1-10)

1~~3~~0. Facility/location. The individual building or buildings, including furnishings and fixtures, or locations where persons with alcohol or substance use disorders receive services. The term "facility" is synonymous with office, clinic, or physical plant. (5-1-10)

1~~4~~1. Governing Body. The individual or individuals, board of directors, group, or agency that has ultimate authority and responsibility for the overall operation of an alcohol and substance use disorders treatment or recovery support services facility or program and for full compliance with these rules and minimum standards. (5-1-10)

1~~5~~2. Group Counseling. The application of formal counseling techniques involving interaction among members of a group of clients. (5-1-10)

1~~6~~3. Guardian. (5-1-10)

a. Under Title 15, Chapter 5, Part 2, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a parent who has not been deprived of custody of his minor and unemancipated child; (5-1-10)

b. Under Title 66, Chapter 3 and 4, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a guardian for a person who is mentally ill or with a developmental disability; or (5-1-10)

c. Under Title 15, Chapter 5, Part 3, Idaho Code, an individual who has been appointed by a court of law to assist any incapacitated person to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person. (5-1-10)

012. DEFINITIONS - I THROUGH P.
For the purposes of these rules, the following terms are used. (5-1-10)

01. Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC). A board affiliated with the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC). The IBADCC is the certifying entity that oversees credentialing of Idaho Student of Addiction Studies (ISAS), Certified Alcohol/Drug Counselors (CADC), Advanced Certified Alcohol/Drug Counselors (ACADC), Certified Clinical Supervisors (CCS), and Certified Prevention Specialists (CPS) in the state of Idaho. The IBADCC may be contacted at: PO Box 1548, Meridian, ID 83680; phone (208) 468-8802; Fax: (208) 466-7693; email: IBADCC@ibadcc.org; http://ibadcc.org/. (5-1-10)

02. Idaho Student of Addiction Studies (ISAS). An entry-level certification for substance use disorder treatment granted by the IBADCC. (5-1-10)

03. Immediate Danger. Exposure to imminent, substantial injury, pain, harm, or loss. (5-1-10)

04. Individualized ~~*Treatment*~~ Service Plan. A written action plan, based on an intake eligibility screening and full clinical assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives, and the criteria for terminating the specified interventions. (5-1-10)

~~***05. Informal Networks**. Informal networks are the web of relationships that people use to exchange resources and services. The content of their exchanges can be work-related, personal, or social. Informal networks are distinct from formal networks in that they are not officially recognized or mandated by organizations. (5-1-10)***~~

0~~6~~5. Intake Eligibility Screening. The collection of data, analysis, and review, which the Department or its designee, uses to screen and determine whether an applicant is eligible for adult or adolescent alcohol or substance use disorders services available through the Department. (5-1-10)

~~***07. Intern**. An individual who has a written agreement with an educational institution that requires a student practicum in a behavioral health care setting. An intern may be referred to as a "Practicum Student," "Student," or an "Idaho Student of Addiction Studies." (5-1-10)***~~

0~~8~~6. Intensive Outpatient Services. An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. (5-1-10)

0~~9~~7. Inventory of Treatments. The various program activities intended to cause or support the reduction or elimination of alcohol or substance use. These activities may include: education, individual, group, or family counseling, vocational rehabilitation services, medical and psychological services, and self-help groups. These services may include activities provided by the program through contractual arrangement with an outside organization. (5-1-10)

~~***10. Level of Service Inventory – Revised (LSI-R)**. An assessment tool used to assess criminal offenders for their risk to commit further offenses and their service needs. The LSI-R is available at this website at http://www.assessments.com/default.asp. (5-1-10)***~~

~~*11*~~08. Licensed Clinical Professional Counselor. An individual licensed in Idaho by the Idaho State Licensing Board of Professional Counselors and Marriage and Family Therapists under Title 54, Chapter 34, Idaho Code. (5-1-10)

~~*12*~~09. Licensed Clinical Social Worker. An individual who has a master's decree or doctorate in social work and two (2) years of postgraduate supervised clinical experience licensed in Idaho by the State Board of Social Work Examiners under Title 54, Chapter 32, Idaho Code. (5-1-10)

1~~3~~0. Licensed Marriage and Family Therapist, Associate Marriage and Family Therapist, or Registered Marriage and Family Therapist Intern. An individual licensed in Idaho by the Idaho State Licensing Board of Professional Counselors and Marriage and Family Therapists under Title 54, Chapter 34, Idaho Code. (5-1-10)

141. Licensed Masters Social Worker. An individual who has a doctorate or master's degree in social work from a college or university licensed in Idaho by the State Board of Social Work Examiners under Title 54, Chapter 32, Idaho Code. (5-1-10)

152. Licensed Professional Counselor. An individual licensed in Idaho by the Idaho State Licensing Board of Professional Counselors and Marriage and Family Therapists under Title 54, Chapter 34, Idaho Code. (5-1-10)

163. Licensed Social Worker. An individual licensed in Idaho by the State Board of Social Work Examiners under Title 54, Chapter 32, Idaho Code. (5-1-10)

174. Management Service Contractor (MSC). An independent contractor with whom the Department contracts to manage a statewide network of Department approved facilities and programs to deliver substance use disorders treatment and recovery support services. (5-1-10)

185. Medical Consultant. A medical consultant provides medical advice in an advisory capacity. For the purpose of this rule a medical consultant is someone who is knowledgeable about medical detoxification procedures. A medical consultant may have worked previously as a nurse, doctor, or other healthcare specialist. (5-1-10)

196. Medical Screening. An examination performed by a licensed professional nurse, nurse practitioner, physician's assistant, or a licensed physician. (5-1-10)

17. Medically Monitored Inpatient Treatment. Medically supervised twenty-four (24) hour care for patients requiring hospitalization and treatment services. Medically monitored inpatient treatment provides treatment services and access to full range of services offered by a hospital. ( )

2018. Mental Health Services. A variety of services for treating mental health disorders that include: emergency services, medication management, assessment, clinical treatment services, case management, family support, and consumer advocacy. (5-1-10)

219. NFPA. The National Fire Protection Association. (5-1-10)

220. Network Provider. A treatment or recovery support services provider who has been approved by the Department and is contracted with the Department's Management Service Contractor. A list of network providers can be found at the Department's website given in Section 005 of these rules. (5-1-10)

231. Nurse. A professional nurse (Registered Nurse or RN) or nurse practitioner licensed in Idaho by the State Board of Nursing under Title 54, Chapter 14, Idaho Code. (5-1-10)

242. Northwest Indian Alcohol/Drug Specialist Certification Board. A board that represents the Native American Chemical Dependency programs in the state of Washington, Oregon, and Idaho and offers certification for chemical dependency counselors. Information regarding certification standards may be obtained at the website at http://www.nwiadcb.com/NWIADCB/index.html. (5-1-10)

2~~5~~3. **On-Site Testing**. Using a device or kit at a treatment or recovery support service facility to test for alcohol or substance use. (5-1-10)

2~~6~~4. **Opioid Replacement Outpatient Services**. This service is specifically offered to a client who has opioids as his substance use disorder. Services are offered under the guidelines of an accredited program incorporated by reference in Section 004 of these rules. (5-1-10)

2~~7~~5. **Outpatient Services**. An organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for alcohol and substance use disorders. (5-1-10)

2~~8~~6. **Physician**. An individual who holds a license issued by the Idaho State Board of Medicine under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho." (5-1-10)

27. Professional Development Plan. A professional development plan: ( )

a. Is developed cooperatively by the clinical supervisor and the clinician; ( )

b. Is clinician-centered; ( )

c. Is customized to the training needs of the clinician; ( )

d. Details the way in which counselor performance may be improved; ( )

e. Is based on counselor knowledge, skill, and attitude; and ( )

f. At a minimum, is informed by use of Department-approved competency rating scales and observations of counselor's clinical work. ( )

2~~9~~8. **Program**. Refers to the organization offering substance use disorders treatment or recovery support services, or both. It includes the organization's facilities, management, staffing pattern, treatment, and related activities. The term "program" is synonymous with the term "facility." (5-1-10)

~~30~~29. **Program Approval**. Refers to the certification under Section 145 of these rules to formally recognize the facility, program, or service as having met the requirements of these rules that pertain to specific substance use disorder treatment services. (5-1-10)

3~~1~~0. **Program Evaluation**. Processes primarily used by the program's administration to assess and monitor, on a regular or continuous basis, program operation, service delivery, quality assurance, and client outcome. (5-1-10)

3~~2~~1. **Provisional Approval**. A temporary certificate of approval issued under Section 145 of these rules to an alcohol and substance use disorders treatment or recovery support services program in operation at the time of promulgation of new rules, in order to afford

reasonable time to comply with the new rules and to obtain approval, or which, while not in full compliance with rules, has no deficiencies which would endanger the health, safety and welfare of clients and is in the process of making the necessary changes to comply fully. (5-1-10)

013. DEFINITIONS - Q THROUGH Z.
For the purposes of these rules, the following terms are used. (5-1-10)

01. Qualified Substance Use Disorders Professional. A professional qualified to provide substance use disorders services under Section 218 of these rules. (5-1-10)

02. Qualified Substance Use Disorders Professional Trainee. An individual practicing in an alcohol and substance use disorders program under Section 223 of these rules. ( )

0~~2~~3. Quality Assurance. An ongoing process of evaluation that ensures compliance with minimum standards and provides for continuous improvements in the quality of services. (5-1-10)

0~~3~~4. Recovery Support Services. Non-clinical services that may include: adult safe and sober housing that is staffed, transportation, child care, family education, life skills education, marriage education, drug testing, peer-to- peer mentoring, and case management. (5-1-10)

0~~4~~5. Referral. The process of linking clients to appropriate treatment and recovery support services. (5-1-10)

0~~5~~6. Release of Information. A signed client authorization to exchange specific treatment information with a specified person or agency. (5-1-10)

0~~6~~7. Residential Treatment Facility. A setting for the treatment of alcohol and substance use disorders that provides twenty-four (24) hour per day, seven (7) days a week, living accommodations for clients. (5-1-10)

0~~7~~8. Screening. A brief process used to determine if an individual meets the program's admission criteria. The screening process is conducted prior to admission to an approved treatment program. (5-1-10)

0~~8~~9. Service. The activities of a treatment or recovery support services program grouped according to a common goal or purpose. Examples of services are Treatment Services, Food Services, Social Services, Nursing Services, Vocational Rehabilitation Services, and services provided to treat an alcohol or substance use disorder. (5-1-10)

10. Service Plan Review. Documented examination of service plans at regular intervals throughout the course of treatment to assess client progress in relation to planned treatment outcomes and make service plan adjustments as necessary. ( )

~~09~~11. Staff Member. An ~~person~~ individual who is directly employed by, or assigned to, a program on either a full or part-time basis. This includes volunteers, contractors, and students of a program. ~~(5-1-10)~~( )

10~~0~~2. Student Practice. A formal education or training program for a student involved in the treatment of alcohol or substance use disorders. (5-1-10)

11~~1~~3. Substance Dependence. Substance dependence is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other substances despite significant related problems. The cluster of symptoms can include: (5-1-10)

a. Tolerance; (5-1-10)

b. Withdrawal or use of a substance in larger amounts or over a longer period of time than intended; (5-1-10)

c. Persistent desire or unsuccessful efforts to cut down or control effects; (5-1-10)

d. Relinquishing important social, occupational or recreational activities because of substance use; and (5-1-10)

e. Continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use as defined in the DSM-IV-TR. (5-1-10)

12~~2~~4. Substance-Related Disorders. Substance-related disorders include disorders related to the taking of alcohol or another substance of abuse, to the side effects of a medication, and to toxin exposures. They are divided into two (2) groups: the Substance Use Disorders and the Substance-Induced Disorders as defined in the DSM-IV-TR. (5-1-10)

13~~3~~5. Substance Use Disorder. Includes Substance Dependence and Substance Abuse, according to the DSM-IV-TR. Substance Use Disorders are one (1) of two (2) subgroups of the broader diagnostic category of Substance-Related Disorders. (5-1-10)

14~~4~~6. Supports. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (5-1-10)

~~***15. Trainee**. An individual who is acquiring the required one thousand forty (1,040) hours of clinical supervised experience in accordance with Section 223 of these rules. (5-1-10)~~

15~~6~~7. Transitional Treatment Facility. A clinically supervised, peer-supported therapeutic environment with clinical involvement that provides twenty-four (24) hours per day, seven (7) days a week, living accommodations for clients. (5-1-10)

16~~7~~8. Treatment(s). The provision of individual therapy, group therapy, assessment, education, and other services to eliminate or reduce alcohol and substance use and arrest, reverse or retard problems associated with alcohol or substance abuse, or both. (5-1-10)

~~***18. Treatment Plan Review**. Documented examination of treatment plans at regular intervals throughout the course of treatment to assess client progress in relation to planned~~

~~*treatment outcomes and make treatment plan adjustments as necessary.* (5-1-10)~~

19. Treatment Supervisor. ~~*The person*~~ A professional qualified under Section 216 of these rules who is responsible for the overall management of all aspects of the provision of a treatment service or multiple treatment services. ~~(5-1-10)~~( )

20. Uniform Fire Code. Refers to the latest edition of the Uniform Fire Code, according to Section 41-253(1), Idaho Code, as minimum standards for the protection of life and property from fire and explosions. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

103. SERVICES FOR CO-OCCURRING DISORDERS (COD).

~~*The objectives of integrated COD treatment services are to keep the client engaged in treatment, improve client outcomes, coordinate mental health and substance use disorders treatment services, and maintain the least restrictive level of care required for successful client outcomes. All approved treatment facilities and programs must be co-occurring capable as defined in Section 010 of these rules. In addition to meeting all the rules and minimum standards contained in Sections 000 through 499 of these rules, each alcohol and substance use disorders treatment services program must meet the following requirements:* (5-1-10)~~

01. Co-Occurring Capable. All alcohol and substance use disorders treatment programs must be co-occurring capable as defined in Section 010 of these rules. (5-1-10)

~~***02. Co-Occurring Disorders**. For clients with co-occurring disorders, coordinated services for these disorders must be provided or arranged, directly or indirectly.* (5-1-10)~~

~~***a.** Each client must have access to a full range of services provided by qualified, trained staff.* (5-1-10)~~

~~***b.** Each client must receive services necessary to fully address his treatment needs. The treatment program must:* (5-1-10)~~

~~*i. Directly provide all necessary services in accordance with the program's capabilities and certification; and* (5-1-10)~~

~~*ii. Provide those services within its capability and promptly arrange additional services from another program as necessary.* (5-1-10)~~

~~***c.** Services must be continuously coordinated between programs, where applicable. Programs must:* (5-1-10)~~

~~*i. Ensure that services are not redundant or conflicting; and* (5-1-10)~~

~~*ii. Maintain communication regarding the individual's treatment plan and progress.*~~

~~*(5-1-10)*~~

~~***03. Duplication of Services.*** *Integrated COD treatment services must not duplicate services currently provided by or under any other state-funded program.* *(5-1-10)*~~

042. COD Competency. All alcohol and substance use disorders treatment staff must demonstrate basic COD competencies as listed in Treatment Improvement Protocol (TIP) 42 - "Substance Abuse Treatment for Persons with Co-Occurring Disorders" incorporated by reference in Section 004 of these rules. (5-1-10)

~~***05. Written Agreements.*** *Alcohol and substance use treatment or recovery support services programs that do not provide COD treatment services must maintain written agreements with other approved programs that will be providing these services. This collaboration must be documented in the client's record.* *(5-1-10)*~~

104. -- 129. (RESERVED)

Application for Approval and Renewal of an Alcohol and Substance Use Disorders Treatment or Recovery Support Services Program (Sections 130 through 159)

130. INITIAL APPLICATION FOR APPROVAL OF AN ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT OR RECOVERY SUPPORT SERVICES PROGRAM.

~~*Application for approval of a program must be made to the Department at least ninety (90) days prior to the planned opening date.* *(5-1-10)*~~

01. Initial Application for Approval. Initial application for approval forms are available upon written request or online at the Department of Health and Welfare website identified in Section 005 of these rules. The applicant must provide the following items to the Department with the application for approval: ~~*(5-1-10)*~~( )

a. A completed and signed Department application form. (5-1-10)

b. A non-refundable application fee for each facility being applied for as follows: (5-1-10)

i. Treatment facility - one hundred dollars ($100); (5-1-10)

ii. Treatment and Recovery Support Services facility - one hundred dollars ($100); and (5-1-10)

iii. Recovery Support Services facility only - fifty dollars ($50). (5-1-10)

c. A written statement that discloses the following with respect to the applicant, owner, or person proposed as executive director: (5-1-10)

i. Any revocation of a license, certification, or approval that is held or previously held in Idaho or any other state or jurisdiction; or (5-1-10)

ii. Other disciplinary action taken, or in the process of being taken in Idaho or any other state or jurisdiction. This includes on-going fraud, waste, and abuse investigations. (5-1-10)

d. A written statement that discloses any issues involving the Internal Revenue Service or Idaho State Tax Commission for the past five (5) years. (5-1-10)

e. A copy of the "Certificate of Assumed Business Name" from the Idaho Secretary of State. (5-1-10)

f. A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings. (5-1-10)

g. Disclosure of ownership as required in Section 160 of these rules. (5-1-10)

h. Copies of current and valid certificates, permits, or licenses as appropriate which may include: (5-1-10)

i. Certificate of occupancy from the local building authority utilizing the latest edition of the Uniform Building Code according to Section 39-4109, Idaho Code, with a determination of either a Group R-1, Congregate Residence of more than ten (10) persons or a Group R-3, Congregate Residence of ten (10) persons or less for each facility site. (5-1-10)

ii. Certificate of fire inspection in accordance with the Uniform Fire Code as adopted by the state fire marshal, with authority delegated to the local fire chief. If an inspection cannot be provided by the local fire department, it is the responsibility of the program to arrange for and, if necessary, to pay for the inspection. (5-1-10)

iii. Food service permit from the district health department, if food is prepared and served at the facility. (5-1-10)

iv. Joint Commission or CARF certificate, if accredited. (5-1-10)

i. Documentation that the menus have been reviewed and approved by a registered dietician within the preceding twelve (12) months if food is prepared and served at the facility. (5-1-10)

j. The written plan for an inventory of treatments as defined in Section 012 of these rules. This plan must include at a minimum: (5-1-10)

i. A statement establishing the geographic area for which the applicant intends to provide services, the proposed location of all offices and facilities; (5-1-10)

ii. A full and complete description of all services the applicant proposes to provide; (5-1-10)

iii. Specific goals and objectives; (5-1-10)

iv. The program's plans to secure additional funding; (5-1-10)

v. A description of the fiscal and information management systems the applicant plans to use; and (5-1-10)

vi. The applicant's plan for measuring and reporting outcomes and results. (5-1-10)

k. A written statement that the applicant, owner, or person proposed as executive director have thoroughly read and reviewed the Alcoholism and Intoxication Treatment Act and these rules and are prepared to comply with all of their respective provisions. (5-1-10)

l. Other information that may be requested by the Department for the proper administration and enforcement of these rules. (5-1-10)

02. Proof of Insurance. The minimum insurance required for all programs is professional liability, commercial general liability, and comprehensive liability for all program vehicles. All facilities must maintain professional liability insurance in the amount of at least five-hundred thousand dollars to one million dollars ($500,000/$1,000,000) and general liability and automobile insurance in the amount of at least one million dollars to 3 million dollars ($1,000,000/$3,000,000). Copies of the declarations face-sheet for all policies must be provided to the Department prior to final approval and before any clients are admitted for services.(5-1-10)

03. Electronic Version of Agency Operating Policies and Procedures. A complete electronic version of the program’s operating policies and procedures based on these rules must be provided with the application. (5-1-10)

04. Identification of the Executive Director, Clinical Supervisor, and Treatment Supervisor. In addition to documentation that demonstrates compliance with Sections 215, 216, 217, and 218 of these rules, the applicant must provide to the Department prior to final approval the following information for the staff identified as Executive Director, Clinical Supervisor, and Treatment Supervisor: (5-1-10)

a. Current resume that includes a detailed work history with start and end dates, job descriptions, and contact information for references. (5-1-10)

b. Copies of applicable licenses and certifications. (5-1-10)

05. Copy of the Lease. A copy of the lease must be provided prior to final approval, if the real property in which the program is located is leased. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

138. JOINT COMMISSION OR CARF ACCREDITATION.

The Department may approve programs or renew a program's certificate of approval based upon Joint Commission or CARF accreditation under the following conditions: (5-1-10)

01. Organization Chart Verifying Staffing Credentials. Organization chart with verification that staff meet minimum credential or certification standards; (5-1-10)

02. Criminal History and Background Checks. Satisfactory evidence that the owner, applicant, person proposed as executive director and all employees, transfers, reinstated former employees, student interns, contractors, volunteers, and any other persons hired or contracted with after May 1, 2010, who provide care or services or have access to clients have successfully passed a criminal history and background check as described in Section 009 of these rules; (5-1-10)

03. Tuberculosis Testing. The personnel policies and procedures must establish tuberculosis testing requirements. All staff members, volunteers, and ~~*student practice/ISAS interns*~~ trainees, must have upon employment, or engagement, and ~~*annually*~~ every three (3) years thereafter, a tuberculin skin test by the Mantoux method, or a blood test for tuberculosis infection. Staff members, volunteers, and ~~*student practice/ISAS interns*~~ trainees who are known to be a positive reactor may have a tuberculosis blood test or chest x-ray examination in lieu of a required tuberculin skin test. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by ~~*laboratory evaluation*~~ a treating physician that the tuberculosis is non-infectious. Results of the testing must be documented in personnel record; and ~~*(5-1-10)*~~( )

04. Application Fee. Payment of non-refundable application or renewal fee as described in Sections 130 and 135 of these rules. (5-1-10)

139. (RESERVED)

140. REVIEW OF APPLICATION AND INSPECTION PROCESS.

01. Departmental Review of Application for Approval or Renewal. Upon receipt of the completed application for approval or renewal of a program, the Department will review and advise the applicant within sixty (60) days if the application meets the requirements of Section 130 or Section 135 of these rules, whichever is appropriate. (5-1-10)

a. If the Department determines the application meets the requirements in Sections 130 or 135 of these rules, the Department will schedule an inspection of the program's facility site(s). The Department will make reasonable efforts to schedule an inspection within thirty (30) days of its determination. (5-1-10)

b. If the Department determines the application does not meet the requirements in Section 130 or 135 of these rules, it will be returned to the applicant, with written recommendations for correction and completion of the recommendations. Failure to meet the application requirements within six (6) months of the original date of application may result in a denial of the application. If the application is denied, the applicant may reapply no sooner than one (1) year from the date of the denial. (5-1-10)

02. Program Facility Inspection. The inspection of the program's facility site(s) will be conducted by a person or persons appointed by the Department. The Department may use the services of any qualified person or organization, either public or private, to examine, survey, or inspect any entity requesting or holding a certificate of program approval. (5-1-10)

a. The applicant's program facility site(s) will be open to Departmental inspection at any reasonable time necessary to determine compliance with these rules and with the "Alcoholism and Intoxication Treatment Act," Sections 39-301, et seq., Idaho Code. Inspections may be made without prior notice to the applicant. (5-1-10)

b. The applicant must, in compliance with federal and state confidentiality requirements, provide for review of the following: (5-1-10)

i. Any and all client records; (5-1-10)

ii. Administrative records; (5-1-10)

iii. Financial statements; (5-1-10)

iv. Other state and local inspection reports; and (5-1-10)

v. Other such documents required by the Department to make its determination, including any information that might have changed since the time the application was submitted. (5-1-10)

c. The applicant must arrange for Departmental inspection of the premises of any of its contractors to determine compliance with applicable requirements of these rules and with the "Alcoholism and Intoxication Treatment Act," Sections 39-301, et seq., Idaho Code. (5-1-10)

03. Responsibility of the Department. Within ~~*sixty*~~ thirty (~~6~~30) days of the date of the inspection, the Department must submit a written report of findings to the applicant. Upon completion of the application and inspection process, the Department may take any of the following actions: ~~*(5-1-10)*~~( )

a. Issue a certificate of approval for a period of two (2) years if a facility is in compliance with the pertinent score in each category and overall weighted score for that length of time as set forth in Subsection 145 of these rules and minimum standards; (5-1-10)

b. Issue a certificate of approval for a period of one (1) year if a facility is in compliance with the pertinent score in each category and overall weighted score for that length of time as set forth in Subsection 145 of these rules and minimum standards; (5-1-10)

c. Issue a provisional certificate of approval for a period of six (6) months contingent on an approved plan to correct all deficiencies prior to the expiration of the provisional certificate if a facility is in compliance with the pertinent score in each category and overall weighted score for that length of time as set forth in Subsection 145 of these rules and minimum standards. A facility will not be issued more than one (1) provisional certificate of approval in any two (2) year period; or (5-1-10)

d. Deny a certificate of approval or renewal. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

210. PERSONNEL POLICIES AND PROCEDURES.
All alcohol and substance use disorders treatment or recovery support services programs must have and adhere to personnel policies and procedures that meet the following standards: (5-1-10)

01. Required Personnel Policies and Procedures. Personnel policies and procedures must be developed, adopted and maintained to promote the objectives of the program and provide for a sufficient number of qualified substance use disorders professionals, treatment and support staff to render the services of the program and provide quality care during all hours of operation. (5-1-10)

a. All personnel policies must be written, reviewed on an annual basis by the executive director and governing body, and signed and dated when reviewed or revised. (5-1-10)

b. The personnel policies must include procedures for recruiting, selecting, promoting and terminating staff. (5-1-10)

c. The personnel policies and procedures must apply to all employees, but may differ with respect to job classifications. (5-1-10)

d. The personnel policies and procedures must include information on the following: (5-1-10)

i. Employee benefits; (5-1-10)

ii. Recruitment and promotion; (5-1-10)

iii. Orientation; (5-1-10)

iv. Training and staff development; (5-1-10)

v. Employee grievances; (5-1-10)

vi. Safety and employee injuries; (5-1-10)

vii. Relationships with employee organizations; (5-1-10)

viii. Disciplinary systems; (5-1-10)

ix. Suspension and termination mechanisms; (5-1-10)

x. Wages, hours and salary administration; (5-1-10)

xi. Rules of conduct; (5-1-10)

xii. Lines of authority; and (5-1-10)

xiii. Performance appraisals and evaluation schedule. (5-1-10)

e. The personnel policies and procedures must include a mechanism for determining that all personnel are capable of performing assigned tasks. (5-1-10)

f. The personnel policies and procedures must ensure that personnel who have a communicable disease, infectious wound or other transmittable condition and who provide care or services to clients or have access to clients are required to implement protective infection control techniques in accordance with these rules. If protective infection control techniques are not implemented, personnel who have a communicable disease, infectious wound or other transmittable condition must not work until the infectious state is corrected and non-infectious; or be reassigned to other areas where contact with others is not expected and the likelihood of transmission of infection is absent; or seek other remedies that will avoid spreading the infection. (5-1-10)

g. The personnel policies and procedures must describe methods and procedures for supervising all personnel, including volunteers and students. (5-1-10)

h. The personnel policies and procedures must assure confidentiality of personnel records and specify who has access to personnel information. (5-1-10)

i. There must be documentation to verify that the policies and procedures are made available to and discussed with each employee at the time of hire and are made available to others upon request. (5-1-10)

j. A mechanism must be established for notifying employees of changes in the policies and procedures. (5-1-10)

k. The personnel policies and procedures must establish tuberculosis testing requirements for all staff members. Each employee must have upon employment, and ~~*annually*~~ every three (3) years thereafter, a tuberculin skin test by the Mantoux method, or tuberculosis blood test. An employee who is known to be a positive reactor may have a tuberculosis blood test or chest x-ray examination in lieu of a required tuberculin skin test. Personnel who have active tuberculosis must be restricted from employment and attendance at the facility until it is determined by ~~*laboratory evaluation*~~ a treating physician that the tuberculosis is non-infectious. Results of the testing must be documented in personnel record. ~~*(5-1-10)*~~( )

l. The personnel policies and procedures must establish the requirement for CPR training and basic first aid training. A minimum of one (1) CPR and First Aid trained staff must be onsite during business hours. Staff responsible for client care must complete this training within ninety (90) days of employment. Additionally, the policies and procedures must establish the methods for renewal of CPR and first aid certification so that they remain current at all times.

(5-1-10)

m. The personnel policies and procedures must establish the provision for criminal history background checks for all employees as described in Section 009 of these rules. (5-1-10)

n. The personnel policies and procedures must establish the provision of clinical supervision. (5-1-10)

o. Policy and procedures must be written that establish a drug free workplace. (5-1-10)

02. Hiring Practices. Hiring practices must be specified in the written policies and procedures and must be consistent with the needs of the program and its services. (5-1-10)

a. The selection of personnel must be based on criteria that are demonstrably related to the job under consideration. (5-1-10)

b. Qualified substance use disorders professional staff must participate in determining what training, experience, and demonstrated competence will be required for assuming specific clinical service responsibility. (5-1-10)

c. There must be documentation to verify that qualified substance use disorders professionals meet all federal, state and local requirements for licensure, registration or certification. (5-1-10)

03. Equal Employment Opportunity. No alcohol and substance use disorders treatment or recovery support services program approved under these rules will discriminate on the basis of race, creed, color, religion, age, gender, national origin, veteran, or disability, except in those instances where bona fide occupational qualifications exist. (5-1-10)

04. Responsible Staff Member to Implement Personnel Policies and Procedures. The executive director must appoint a staff member to implement and coordinate personnel policies and procedures to accomplish the following tasks: (5-1-10)

a. Develop a written organizational plan for personnel services; (5-1-10)

b. Maintain personnel records; (5-1-10)

c. Disseminate employment information to staff; (5-1-10)

d. Develop staff orientation programs; (5-1-10)

e. Implement procedures designed to assure compliance with federal, state and local laws related to employment practices; and (5-1-10)

f. Supervise the processing of employment-related forms. (5-1-10)

05. Contents of Personnel Record for Each Staff Member. A personnel record must

be kept on each staff member and must contain the following items: (5-1-10)

a. Application for employment including a record of the employee's education or training and work experience. This may be supplemented by a resume; (5-1-10)

b. A written record of all findings from verbal contacts with references, and letters of recommendation; (5-1-10)

c. Verification of licensure, certification, registration or renewals; (5-1-10)

d. A signed and dated commitment to a code of ethics appropriate for alcohol and substance use disorders treatment staff; (5-1-10)

e. Number of hours per pay period, wage and salary information, including all adjustments; (5-1-10)

f. Performance appraisals or contract compliance evaluation; ~~*(5-1-10)*~~( )

g. Counseling actions; (5-1-10)

h. Disciplinary actions; (5-1-10)

i. Commendations; (5-1-10)

j. Employee incident reports; (5-1-10)

k. A Department criminal history check; (5-1-10)

l. Results of tuberculosis testing, treatment taken, including dates of treatment, for tuberculosis infection; ~~*(5-1-10)*~~( )

m. Verification of employee and emergency orientation procedures; and (5-1-10)

n. Verification of current cardiopulmonary resuscitation (CPR) training and basic first aid training, in accordance with the requirements under Subsection 01.l. of this rule and under Subsections 392.03, 520.03.d., and 520.04. For employees in direct care at Residential Social Detoxification Settings, verification of additional training specific to detoxification prior to being charged with the responsibility of client care. ~~*(5-1-10)*~~( )

06. Job Description for a Position in the Program. For each position in the program, there must be a written job description that specifies the duties and responsibilities of the position and the minimum level of education, training or related work experience required or needed to fulfill it. (5-1-10)

a. Each job description must specify the following: (5-1-10)

i. The position title; (5-1-10)

ii. The program, department, service, or unit; (5-1-10)

iii. Direct supervisor's title; (5-1-10)

iv. Positions supervised, if any; (5-1-10)

v. Clear descriptions of job functions; and (5-1-10)

vi. Clinical, administrative, and procedural responsibility and authority. (5-1-10)

b. Each job description must accurately reflect the job and must be revised whenever a change in qualifications, duties, supervision, or any other major job-related factor is made. (5-1-10)

c. Each job description must be comprehensive enough to enable a new employee to understand the position, job functions, responsibility, chain-of-command, and authority. (5-1-10)

d. Each job description must be sufficiently detailed to serve as a basis for performance appraisals. (5-1-10)

07. Performance Appraisals. Performance appraisals must be conducted and must be related to the job description and job performance. (5-1-10)

a. The criteria used to evaluate job performance must be measurable and relate to the skills, knowledge and attitudes that the job requires. (5-1-10)

b. Performance appraisals must be conducted, at a minimum, annually. (5-1-10)

c. Performance appraisals must be in writing. (5-1-10)

d. There must be documentation to verify that the employee has reviewed the evaluation and has had an opportunity to comment on it. The employee must sign the appraisal after review and comments are completed. (5-1-10)

e. The program must develop policies and procedures to follow when there is a serious discrepancy between the staff member's actual job performance and the criteria for an acceptable level of job performance. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

216. SUPERVISORY STAFF QUALIFICATIONS.
Qualifications of the supervisory staff must be verified through written documentation of work experience, education, and classroom instruction. The supervisory staff must meet the requirements in Section 218 of these rules and the following requirements: (5-1-10)

01. Treatment Supervisor. The Treatment Supervisor must meet the requirements in

Section 218 of this rule and ~~*have a combination of education and experience as*~~ meet one (1) of the follow~~s~~ing: ~~*(5-1-10)*~~( )

a. Equivalent of five (5) years full-time paid professional experience providing alcohol and substance use disorders treatment with at least two (2) of the five (5) years providing direct treatment in a state, federal, Joint Commission, or CARF-approved behavioral health services program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. This experience must be relevant for child and adolescent treatment if supervising treatment in a child and adolescent treatment program; or ~~*(5-1-10)*~~( )

b. Bachelor's Degree in relevant field and four (4) years paid full-time professional experience with two (2) years in direct treatment in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority; or (5-1-10)

c. Master's Degree and three (3) years paid full-time professional experiences with two (2) years in direct treatment in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~*; and*~~. ~~*(5-1-10)*~~( )

~~***d.*** *Equivalent of one (1) year paid full-time supervision experience of alcohol and substance use disorders treatment services in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority or have a Clinical Supervisor designation from the Idaho Bureau of Occupational Licenses; and* *(5-1-10)*~~

~~***e.*** *Knowledge and experience in providing alcohol and substance use disorders treatment including client evaluation, counseling techniques, relapse prevention, case management, and family therapy.* *(5-1-10)*~~

02. Clinical Supervisor. The Clinical Supervisor must meet the requirements in Section 218 of this rule and ~~*have a combination of education and experience as*~~ meet the follow~~s~~ing: ~~*(5-1-10)*~~( )

a. Master's Degree from an accredited, approved, and recognized college or university in health and human services and the equivalent of four (4) years paid full-time professional experience with three (3) years providing direct substance use disorders treatment and one (1) year paid full-time supervision experience in a ~~*substance use disorders treatment services*~~ state, federal, Joint Commission, or CARF-approved behavioral health services program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority or have a Clinical Supervisor designation from the Idaho Board of Occupational Licensure. This experience must be relevant for child and adolescent treatment if supervising treatment in child and adolescent treatment programs; or ~~*(5-1-10)*~~( )

b. IBADCC Certified Clinical Supervisor; (5-1-10)

~~***c.*** *Knowledge and experience demonstrating competence in alcohol and substance use disorders treatment including client evaluation, counseling techniques, relapse prevention, case management, and family therapy; and*~~ ~~*(5-1-10)*~~

~~***d***~~**c.** For outpatient programs providing services to children and adolescents, the clinical supervisor must have two (2) years of experience working with families or children in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority. Working knowledge of child and adolescent growth and development, and the effects of alcohol and drugs on a child's growth and development. (5-1-10)

~~***e***~~**d.** A clinical supervisor must have completed the Clinical Supervision training model as identified by the Department. The Clinical Supervision training must be completed within one hundred eighty (180) days of date of hire or date of designation as clinical supervisor. (5-1-10)

~~***f.*** *A Clinical Supervisor for Co-Occurring Disorders Enhanced Programs must meet all requirements in Subsection 216.02.b. of this rule, have a Master's Degree from an accredited, approved, and recognized college or university in health and human services, and possess a current Idaho state license to provide behavioral health clinical services.*~~ ~~*(5-1-10)*~~

217. CLINICAL SUPERVISION.
The alcohol and substance use disorders treatment program must provide for supervision of all clinical activities by qualified substance use disorders professionals including: (5-1-10)

01. Inventory of Treatments Written Plan. A written plan for an inventory of treatments providing and defining the procedure for the supervision of all clinical activities by qualified substance use disorders professionals; (5-1-10)

02. Specific Treatment Responsibilities. All members of the treatment team who have been assigned specific treatment responsibilities must be qualified by training or experience and demonstrated competence; (5-1-10)

03. Supervision by a Clinical Supervisor. All members of the treatment team must be supervised by a clinical supervisor as defined in Section 010 of these rules; (5-1-10)

04. Evaluation of Competencies. Clinical supervision must include a documented evaluation of the competencies of the members of the clinical staff, and a plan of activities which bring those competencies to proficiency. The evaluation will be conducted within one (1) month of initial hire and annually thereafter. Documentation of the evaluation and a record of improvement activities must be present in each Clinical Supervision record. The clinical supervision record must contain at a minimum: (5-1-10)

a. Demographic information including name, date of hire, credential, and position; (5-1-10)

b. ~~*Learning*~~ Professional Development ~~*p*~~Plan(s) as defined in Section 012 of these rules; ~~*(5-1-10)*~~( )

c. Observation documentation; (5-1-10)

d. Competency rating forms; (5-1-10)

~~***e.*** *Intensive supervision plan, if required;* *(5-1-10)*~~

~~***f***~~**e.** Current resume; and (5-1-10)

~~***g***~~**f.** Documentation of clinical supervision activities which include date of clinical supervision, type of clinical supervision activity, length of time spent performing the clinical supervision activity. (5-1-10)

218. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL PERSONNEL REQUIRED.
The alcohol and substance use disorders program must employ the number and variety of staff to provide the services and treatments offered by the program as a multidisciplinary team. The program must employ at least one (1) qualified substance use disorders professional for each facility. (5-1-10)

01. Qualified Substance Use Disorders Professional. A qualified substance use disorders professional includes the following: (5-1-10)

a. IBADCC Certified Alcohol/Drug Counselor; (5-1-10)

b. IBADCC Advanced Certified Alcohol/Drug Counselor; (5-1-10)

~~***c.*** *Native American Certified Alcohol and Drug Abuse Counselor (NACADC);* *(5-1-10)*~~

~~***d***~~**c.** Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III; (5-1-10)

~~***e***~~**d.** National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC); (5-1-10)

~~***f***~~**e.** "Licensed Clinical Social Worker" (LCSW) or a "Licensed Masters Social Worker" (LMSW) licensed under Title 54, Chapter 32, Idaho Code~~*, who holds one (1) of the certifications under Subsections 218.01.a. through 218.01.e. of this rule or has one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment, in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority*~~; ~~*(5-1-10)*~~( )

~~***g***~~**f.** "Marriage and Family Therapist~~,~~" ~~*"Registered Marriage and Family Therapist*~~

~~Intern,"~~ or "Associate Marriage and Family Therapist," licensed under Title 54, Chapter 34, Idaho Code~~, who holds one (1) of the certifications under Subsections 218.01.a. through 218.01.e. of this rule or has one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment, in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~; ~~(5-1-10)~~( )

~~h~~g. "Nurse Practitioner" licensed under Title 54, Chapter 14, Idaho Code~~, may provide substance use disorder services. A nurse practitioner must have one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment, in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~; ~~(5-1-10)~~( )

~~i~~h. "Clinical Nurse Specialist" licensed under Title 54, Chapter 14, Idaho Code~~, may provide substance use disorder services. A clinical nurse specialist must have one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~; ~~(5-1-10)~~( )

~~j~~i. "Physician Assistant" licensed under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants"~~ may provide substance use disorder services. A physician assistant must have one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF- approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~; ~~(5-1-10)~~( )

~~k~~j. "Licensed Professional Counselor" (LPC) or a "Licensed Clinical Professional Counselor" (LCPC) licensed under Title 54, Chapter 34, Idaho Code~~, who holds one (1) of the certifications under Subsections 218.01.a. through 218.01.e. of this rule or has one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment, in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~; ~~(5-1-10)~~( )

~~l~~k. "Psychologist," or a "Psychologist Extender" licensed under Title 54, Chapter 23, Idaho Code~~ with a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders as issued by the College of Professional Psychology, or who holds one (1) of the certifications under Subsections 218.01.a. through 218.01.e. of this rule or has one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment, in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through~~

~~their Single State Authority~~; ~~(5-1-10)~~( )

~~m~~l. "Physician" licensed under Title 54, Chapter 18, Idaho Code~~, may provide substance use disorder services. A licensed physician must have one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment~~; ~~(5-1-10)~~( )

~~n~~m. "Professional Nurse" RN licensed under Title 54, Chapter 14, Idaho Code~~, may provide substance use disorder services. An RN must have one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARF-approved program. State approval includes other states that are approved, licensed, or certified to provide substance use disorders treatment services through their Single State Authority~~. ~~(5-1-10)~~( )

02. Qualified Substance Use Disorders Professional Status Granted Prior to May 1, 2010. Subsections 218.01 and 218.02 of this section are applicable to all new applications for appointment as a qualified Substance Use Disorders Professional submitted to the Department after May 1, 2010. If an individual was granted an appointment prior to May 1, 2010, and met the requirements at that time, he may continue to have his appointment recognized.~~ The appointment of this status will be given by the Department after the Department has received documentation affirming the qualified substance use disorder professional's education and experience meets standards in place prior to May 1, 2010.~~ ~~(5-1-10)~~( )

03. Arrangement for Provision of Counseling Services. If the program arranges for the provision of counseling services, it must maintain a valid written agreement or contract with a qualified substance use disorders professional as defined in Subsection 218.01 of this section. (5-1-10)

219. -- 220. (RESERVED)

221. VOLUNTEERS.
Alcohol and substance use disorders treatment or recovery support services programs that utilize volunteers must meet the following requirements. (5-1-10)

01. Objectives and Scope of Volunteer Services. In programs where volunteers are utilized, the objectives and scope of the volunteer services must be clearly stated in writing. The statement must be reviewed at least annually and signed and dated by the executive director or his designee. (5-1-10)

02. Orientation of Volunteers to Program Goals, Objectives, and Services. An orientation must be conducted to familiarize volunteers with the program's goals, objectives and services and to provide clinical orientation regarding the program's clients. At a minimum, the orientation must address at least the following: (5-1-10)

a. The individual responsible for supervising the volunteer; (5-1-10)

b. The requirements of maintaining confidentiality and protecting client's rights; (5-1-10)

c. The emergency policies and procedures; and (5-1-10)

d. The program's channels of communication and the distinctions between administrative and clinical authority and responsibility. (5-1-10)

03. Supervision of Volunteers. Volunteers must be under the direct supervision of the staff of the program, service or unit utilizing their services and must receive general direction and guidance. (5-1-10)

a. When volunteers are used as members of treatment teams, they must supplement the total treatment program only under the direct supervision of qualified substance use disorders professionals and after consideration of client's needs. (5-1-10)

b. Qualified substance use disorders professionals must be available to help volunteers establish the most effective relationship with clients. (5-1-10)

c. Procedures must be established to assure that the observations of a volunteer are reported to the qualified substance use disorders professional staff member responsible for the client. These observations may be recorded in the client's record. (5-1-10)

04. Volunteer Activity Records. Volunteer activity records and reports must contain information that can be used to evaluate the effectiveness of the volunteers, based on effectiveness criteria identified by the program. (5-1-10)

05. Criminal History Check for Volunteers. Volunteers ~~*hired or contracted with after May 1, 2010,*~~ must submit to a criminal history and background check under Section 009 of these rules. ~~*(5-1-10)*~~( )

06. Tuberculosis Testing Requirements. Under Section 210 of these rules, the personnel policies and procedures must establish tuberculosis testing requirements for all volunteers. (5-1-10)

222. (RESERVED)

223. ~~*STUDENT/ISAS/TRAINEE -- PRACTICE*~~ QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL TRAINEE.
Each ~~*student/ISAS/*~~ qualified substance use disorders professional trainee practicing in an alcohol and substance use disorders treatment program must meet the requirements in these rules.
~~*(5-1-10)*~~( )

01. Written Agreement Required for Students. When the participant is involved with an educational institution to obtain their practicum, the program must have a written agreement with the educational institution that defines the nature and scope of student activities within the program. (5-1-10)

02. Supervision of ~~*Student/ISAS/*~~ Qualified Substance Use Disorders Professional Trainee. Each ~~*student/ISAS/*~~ qualified substance use disorders professional trainee practicing in the alcohol and substance use disorders treatment program must be supervised by a qualified

substance use disorders professional. There must be a qualified substance use disorders professional on duty at all times providing appropriate oversight. ~~(5-1-10)~~( )

03. Informed of ~~Student/ISAS/~~ Qualified Substance Use Disorders Professional Trainee Providing Treatment. All staff, clients, their families or guardians must be informed when a ~~student/ISAS/~~ qualified substance use disorders professional trainee is providing client treatment. ~~(5-1-10)~~( )

04. ~~Student/ISAS/~~ Qualified Substance Use Disorders Professional Trainee Criminal History Check. A ~~student/ISAS/trainee hired or contracted with after May 1, 2010,~~ qualified substance use disorders professional trainee must submit to a criminal history check in accordance with the provisions of Section 009 of these rules. ~~(5-1-10)~~( )

05. ~~Student/ISAS/~~ Qualified Substance Use Disorders Professional Trainee Job Description. ~~Student/ISAS/~~ Qualified substance use disorders professional trainee status must be indicated by their job description and title presented to the public and clients. The job description must include the responsibilities of receiving supervision and maintaining documentation of the supervision plan. ~~(5-1-10)~~( )

~~**06. Student/ISAS/Trainee Length of Appointment Status**. Student/ISAS/trainee status is restricted to no more than three calendar (3) years from appointment to student/ISAS/trainee status. A student/ISAS/trainee who has not achieved counselor status must show an increased scope of work, with increased proficiency, as documented in the clinical supervision record.~~
~~(5-1-10)~~

0~~7~~6. Orientation of ~~Student/ISAS/~~ Qualified Substance Use Disorders Professional Trainee. An orientation must be conducted to familiarize individuals with the program's goals, objectives, and services and to provide clinical orientation regarding the program's clients. At a minimum, the orientation must address at least the following: ~~(5-1-10)~~( )

a. Person responsible to supervise ~~student/ISAS/~~ qualified substance use disorders professional trainee. ~~(5-1-10)~~( )

b. The requirements of maintaining confidentiality and protecting client's rights; (5-1-10)

c. The emergency policies and procedures; and (5-1-10)

d. The program's channels of communication and the distinctions between administrative and clinical authority and responsibility. (5-1-10)

0~~8~~7. Work Qualifications for ~~Students~~ Qualified Substance Use Disorders Professional Trainee. Clinical staff designated as a ~~student/ISAS/~~ qualified substance use disorders professional trainee and who with intensive supervision would be allowed to gradually add the tasks of a qualified substance use disorders professional, must have one (1) of the following levels of qualification to begin work: ~~(5-1-10)~~( )

a. Idaho Student in Addiction Studies (ISAS); (5-1-10)

~~**b.** *Formal designation from the ICRC of trainee status;* (5-1-10)~~

~~**c.** *Formal documentation as a Native American Certified Alcohol and Drug Abuse Counselor Intern;* (5-1-10)~~

~~**d**~~**b.** Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor ~~*Intern*~~*I*; ~~(5-1-10)~~( )

c. Formal documentation of current enrollment in a program in accordance with the qualifications of Section 218 of these rules. ( )

~~**e.** *"Licensed Clinical Social Worker" (LCSW) or a "Licensed Masters Social Worker" (LMSW) licensed under Title 54, Chapter 32, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**f.** *"Marriage and Family Therapist," "Registered Marriage and Family Therapist Intern," or "Associate Marriage and Family Therapist" licensed under Title 54, Chapter 34, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**g.** *"Nurse Practitioner" licensed under Title 54, Chapter 14, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**h.** *"Clinical Nurse Specialist" licensed under Title 54, Chapter 14, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**i.** *"Physician Assistant" licensed under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants" may provide substance use disorder services., with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**j.** *"Licensed Professional Counselor" (LPC) or a "Licensed Clinical Professional Counselor" (LCPC) licensed under Title 54, Chapter 34, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**k.** *"Psychologist" or a "Psychologist Extender" licensed under Title 54, Chapter 23, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment;* (5-1-10)~~

~~**l.** *"Physician" licensed under Title 54, Chapter 18, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment; or* (5-1-10)~~

~~***m.*** *"Professional Nurse" RN licensed under Title 54, Title 14, Idaho Code, with documentation that he is currently engaged in obtaining one thousand forty (1,040) hours of supervised experience providing substance use disorder treatment.* ***(5-1-10)***~~

~~***n***~~**d.** Individuals listed in Subsection 223.0~~*8*~~7.a. through 223.0~~*8*~~7.~~*m*~~c. of this Section, working with children and adolescents, must document coursework specific to human development and child and adolescent behavior. ~~***(5-1-10)***~~( )

0~~*9*~~8. Tuberculosis Testing Requirements for ~~*Students***~~ Qualified Substance Use Disorders Professional Trainee**. Under Section 210 of these rules, the personnel policies and procedures must establish tuberculosis testing requirements for all ~~*students/ISAS/*~~ qualified substance use disorders professional trainees. ~~***(5-1-10)***~~( )

(BREAK IN CONTINUITY OF SECTIONS)

350. CLIENT RIGHTS.
All alcohol and substance use disorders treatment or recovery support services programs must have written policies and procedures to protect the fundamental human, civil, constitutional, and statutory rights of each client. (5-1-10)

01. General Rights. The client rights policies and procedures must address the following: (5-1-10)

a. The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age, or disability; (5-1-10)

b. Respect for personal dignity in the provision of all care and treatment; (5-1-10)

c. The right to humane services, regardless of the source of financial support; (5-1-10)

d. The right to receive services within the least restrictive environment possible; (5-1-10)

e. The right to an individualized ~~*treatment*~~ service plan, based on assessment of current needs; ~~***(5-1-10)***~~( )

f. The right of the client to participate in planning for treatment and recovery support services; and (5-1-10)

g. The right of the client to request Department staff review the ~~*treatment*~~ service plan or the services provided. ~~***(5-1-10)***~~( )

02. Personal Privacy. Each client's personal privacy must be assured and protected within the constraints of the individual ~~*treatment*~~ service plan. ~~***(5-1-10)***~~( )

a. The client's family and significant others, regardless of their age, must be allowed to visit the client, during regular hours of visitation, unless such visits are clinically contraindicated. (5-1-10)

b. Suitable areas must be provided for clients to visit in private, unless such visits are clinically contraindicated. (5-1-10)

c. Clients in residential settings must be allowed to send and receive mail without hindrance, unless clinically contraindicated. (5-1-10)

d. Clients in residential settings must be allowed to conduct private telephone conversations with family and friends, unless clinically contraindicated. (5-1-10)

e. If individual therapeutic indications in residential settings necessitate restrictions on visitors, telephone calls or other communications, those restrictions must be evaluated for therapeutic effectiveness by a qualified substance use disorders professional at least every three (3) days. (5-1-10)

f. Any restrictions on visitors, telephone calls or other communications must be fully explained to the client and the client's family. (5-1-10)

03. Visitation. There must be written procedures designed to protect clients' rights and privacy with respect to visitors in outpatient and residential programs. (5-1-10)

a. The client must be informed in advance of educational or other individual or group visitations available through the alcohol and substance use disorders treatment program. (5-1-10)

b. Visitations to the alcohol and substance use disorders treatment program's facility must be conducted so as to limit disruption of the client's usual activities and treatment processes. (5-1-10)

04. Individualized ~~*Treatment*~~ Service Plan Review. Each client will have the right to request the opinion of a consultant at his own expense or to request an in-house review of the individualized ~~*treatment*~~ service plan, as provided in specific procedures of the program.
~~*(5-1-10)*~~( )

05. Client to Be Informed of Rights. Each client must be informed of his rights. (5-1-10)

a. Each client must be given a written statement of client rights, which includes who the client may contact with questions, concerns or complaints regarding services provided. (5-1-10)

b. Copies of the program's client rights statement must be posted in conspicuous places at all sites. (5-1-10)

06. Client and Family to Be Informed Regarding Care and Treatment. The client

and, where there is a valid release of information, the client's family must be fully informed regarding: (5-1-10)

a. Client's rights; (5-1-10)

b. The name, professional status and position of staff members responsible for the client's care; (5-1-10)

c. The nature of care, treatment and procedures that the client will receive; (5-1-10)

d. The current and future use and disposition of products of special observation and audiovisual techniques, such as one-way mirrors, tape recorders, video recorders, television, movies or photographs; (5-1-10)

e. Specific risk, benefit, or side effects of clinical care associated with their ~~*treatment*~~ service plan. This informed consent will address common risk or benefits associated with treatment and is not meant to be all-inclusive to every risk, benefit, or side effect; ~~*(5-1-10)*~~( )

f. Alternative treatment procedures that are available; (5-1-10)

g. The right to refuse to participate in any research project without compromising his access to program services; (5-1-10)

h. The right to refuse specific treatment procedures; (5-1-10)

i. As appropriate, the cost, itemized when possible, of services rendered; (5-1-10)

j. The source of the program's reimbursement and any limitations placed on duration of services as it relates to each client's financial circumstance; (5-1-10)

k. The reasons for any proposed change in the professional staff responsible for the client or for any transfer of the client within or outside of the program; (5-1-10)

l. The rules and policies of the program applicable to client conduct; (5-1-10)

m. The right to initiate a complaint or grievance procedure and the means to request a hearing or review of the complaint. (5-1-10)

n. The plan for discharge ~~*plan*~~; and ~~*(5-1-10)*~~( )

o. The plans for recovery support activities following discharge. (5-1-10)

07. Informed Consent. In accordance with the requirements of any applicable law or any applicable standard contained in these rules, a written, dated, and signed informed consent form must be obtained from the client, the client's family or the client's guardian, as appropriate, for participation in any research project or other procedures or activities where informed consent is required by law. (5-1-10)

08. Client Abuse and Neglect. Every alcohol and substance use disorders treatment or recovery support services program must have written policies and procedures for handling cases of client abuse and neglect. (5-1-10)

a. The policies and procedures on client abuse and neglect must be given to all personnel and must be made available to others upon request. (5-1-10)

b. The policies and procedures must ensure the reporting within twenty-four (24) hours to the proper law enforcement agency or to the Department of any allegations of client abuse and neglect under the following: (5-1-10)

i. "Idaho Child Protective Act," Section 16-1619, Idaho Code, for minors; and (5-1-10)

ii. "Adult Abuse, Exploitation, and Abandonment Act," Section 39-5303, Idaho Code, for adults. (5-1-10)

c. Any and all alleged violations of the policies and procedures must be investigated. (5-1-10)

d. There must be documentation that the results of such investigation must be reviewed and approved by the executive director and reported to the governing body. (5-1-10)

351. -- 359. (RESERVED)

360. ADMISSION POLICIES AND PROCEDURES.
All alcohol and substance use disorders treatment or recovery support services programs must have policies and procedures governing the admission process. These must be available to clients and their families and to the general public. (5-1-10)

01. Admission Policies. The admission policies and procedures must be in writing and must specify the following: (5-1-10)

a. Criteria for determining the eligibility of individuals for admission in accordance with ASAM placement criteria; (5-1-10)

b. The information to be obtained on all applicants or referrals for admission; (5-1-10)

c. The procedures for accepting referrals from outside agencies and organizations; (5-1-10)

d. The records to be kept on all applicants; (5-1-10)

e. The statistical data, as determined by the Department's MSC, to be kept on the admission process; and (5-1-10)

f. The procedures to be followed, including alternative referrals, when an applicant is

found ineligible for admission. (5-1-10)

02. Screening. Screening must be based on the needs of clients as identified as follows: (5-1-10)

a. The screening is conducted prior to admission to treatment to determine if the client meets the admission criteria; (5-1-10)

b. The screening must be interpreted by a qualified substance use disorders professional; and (5-1-10)

c. The results of the screening must be clearly explained to the client, and family when appropriate. (5-1-10)

03. Acceptance for Treatment. Acceptance of a client for treatment must be based on an admission procedure that assures the following: (5-1-10)

a. The care provided by the program at that facility site is appropriate for the client and must be based on admission, continued stay, and discharge criteria approved by the Department; (5-1-10)

b. Assessment data is collected to develop a preliminary ~~*treatment*~~ service plan; ~~*(5-1-10)*~~( )

c. If the potential client is a minor or an incompetent person, a parent, guardian, or other legal representative may make application for voluntary admission to treatment; and (5-1-10)

d. No otherwise qualified individual is denied access to treatment services on the basis of race, creed, color, religion, gender, national origin, age, or disability. (5-1-10)

e. Acceptance for treatment is based on the program's scope of practice, capability, and capacity. (5-1-10)

04. Provisions for Persons Requiring Protective Custody. For persons coming voluntarily or being brought by a law enforcement officer to an alcohol and substance use disorders treatment program for protective custody, the program must comply with the provisions of Section 39-307A, Idaho Code. (5-1-10)

05. Assure Applicants Understand Rights and Responsibilities. During the admission process, every effort must be made to assure that applicants understand the following: (5-1-10)

a. The nature and goals of the treatment program; (5-1-10)

b. The hours during which services are available; (5-1-10)

c. The treatment costs, if any, to be borne by the client; and (5-1-10)

d. The rights and responsibilities of clients, including the rules governing client conduct and the types of infractions that can result in disciplinary action or discharge from the program. (5-1-10)

06. Reasonable Precautions in All Admissions. Reasonable precautions must be taken in all admissions to ensure the safety of the client, other clients, staff of the program, and members of the community. Reasonable precautions are those that are fair, proper, or moderate under the circumstances. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

375. CLIENT RECORDS REQUIREMENTS.
Each alcohol and substance use disorders treatment or recovery support services program must meet the client records requirements set forth in these rules. (5-1-10)

01. ~~*Written*~~ Client Record Required. The alcohol and substance use disorders treatment or recovery support services program must maintain a ~~*written*~~ client record on each client. All entries in the client record must be signed and dated. Symbols and abbreviations may be used. An abbreviations legend must be available for the Department to review. The abbreviations legend must be located in the client record for reference. ~~*(5-1-10)*~~( )

02. Content of Client Record. The client record must describe the client's situation at the time of admission and include the services provided, all progress notes, and the client's status at the time of discharge. At a minimum the record must contain: (5-1-10)

a. ~~*Identifying data including t*~~The client's name, ~~*home*~~ address, ~~*home telephone number*~~ contact information, date of birth, gender, marital status, race or ethnic origin, next of kin or person to contact, educational level, type and place of employment, date of initial contact or admission to the program, source of any referral, legal status including relevant legal documents, name of personal physician, record of any known drug reactions or allergies, and other identifying data as indicated. ~~*(5-1-10)*~~( )

b. The identifying data as described in Subsection 375.02.a. of these rules must be dated with the date the information was gathered and signed by the staff member gathering the information. (5-1-10)

c. All staffing notes pertaining to the client. ( )

d. All medical records regarding the client. These may include documentation of a medical examination, results of any medical tests, including drug and alcohol screening tests performed by the program, and results of any medical tests reported to the program which were performed outside the program. ( )

e. Documentation that justifies the client meets criteria for admission, continued stay,

and discharge. The documentation must be based on admission, continued stay and discharge criteria approved by the Department. ( )

03. Assessments Completed With the Client. All assessments completed with the client must be dated, signed by the person providing the assessment, and give a full accounting of the findings of such assessments. (5-1-10)

04. Progress Notes. Notes for each ~~*treatment session*~~ service charting the client's progress must include: ~~*(5-1-10)*~~( )

a. Date of session; (5-1-10)

b. Beginning and ending time of session; (5-1-10)

c. Description of the session and; ~~*(5-1-10)*~~( )

d. Signature of person conducting the session~~;~~.. ~~*(5-1-10)*~~( )

~~***e.*** *All staffing notes pertaining to the client;* *(5-1-10)*~~

~~***f.*** *All medical records regarding the client. These may include documentation of a medical examination, results of any medical tests, including drug and alcohol screening tests performed by the program, and results of any medical tests reported to the program which were performed outside the program; and* *(5-1-10)*~~

~~***g.*** *Documentation that justifies the client meets criteria for admission, continued stay, and discharge. The documentation must be based on admission, continued stay and discharge criteria approved by the Department.* *(5-1-10)*~~

05. ~~*Unusual*~~ Client-Specific Occurrences. The client record must contain information on any ~~*unusual*~~ client-specific occurrences, such as: ~~*(5-1-10)*~~( )

a. Treatment complications; (5-1-10)

b. Accidents or injuries to the client; (5-1-10)

c. Serious illness; (5-1-10)

d. Death of the client.~~ *In the event of a client's death, the person must be pronounced dead in accordance with the provisions of Idaho law and a summation statement must be entered in the record in the form of a discharge summary.* *(5-1-10)*~~( )

06. ~~*Telephone Calls*~~ Correspondence. The client record must contain signed and dated documentation of any correspondence concerning the client's ~~*treatment and signed and dated notations of telephone calls concerning the client's treatment*~~ recovery. ~~*(5-1-10)*~~( )

~~***07. Discharge Plan.*** *The client record must contain a plan for discharge.* *(5-1-10)*~~

0~~8~~7. Discharge Summary. A discharge summary must be entered in the client record within ~~*a reasonable period of time not to exceed*~~ fifteen (15) days following discharge~~*, as determined by the professional staff and policies or standards.*~~ and must contain a summary of the following: ~~*(5-1-10)*~~( )

a. Client status at discharge; ( )

b. Treatment progress; ( )

c. Summary of services to be provided after discharge; and ( )

d. Referrals for further treatment. ( )

376. MAINTENANCE OF CLIENT RECORDS.
Every alcohol and substance use disorders treatment or recovery support services program must maintain, control and supervise client records and is responsible for maintaining their quality in accordance with the requirements set forth in these rules. (5-1-10)

01. Active Client Records Kept at the Facility Site. The active client's records must be kept at the facility site where the client is being treated. (5-1-10)

02. Compilation, Storage, Dissemination, and Accessibility of Client Records. The program must have written policies and procedures governing the compilation, storage, dissemination, and accessibility of client records. The policies and procedures must be designed to ensure: (5-1-10)

a. The program fulfills its responsibility to safeguard and protect client records against loss, unauthorized alteration or disclosure of information; (5-1-10)

b. In the event of unauthorized release of client identifying information such as theft, the Department is notified immediately; ~~*(5-1-10)*~~( )

c. In the event of closure of program how and where records will be stored; (5-1-10)

d. Each client record contains all required information; (5-1-10)

e. Uniformity in the format and forms is used in client records; (5-1-10)

03. Entries in Client Records Are Dated and Signed. The policies and procedures must require entries in client records to be dated and signed. (5-1-10)

04. Storage Facilities. The program must provide facilities for the storage, processing and handling of client records, including locked and secured rooms and files. (5-1-10)

05. Electronic Storage of Client Data. When a program stores client data in electronic or other types of automated information systems, they must have security measures to prevent inadvertent or unauthorized access to such data. (5-1-10)

06. Length of Maintenance of Client Records. Client records must be maintained for a minimum of five (5) years from the date they are officially closed. (5-1-10)

07. Disposal of Client Records. The program must have a written policy governing the disposal of client records. Methods of disposal must be designed to assure the confidentiality of client information. (5-1-10)

08. Confidentiality and Disclosure of Information. The program must have written policies and procedures that protect the confidentiality of client records and govern the disclosure of information in the records under Section 006 of these rules. (5-1-10)

377. -- 379. (RESERVED)

380. INDIVIDUALIZED ~~*TREATMENT*~~ SERVICE PLAN.

01. Individualized ~~*Treatment*~~ Service Plan. ~~*A state-approved alcohol and substance use disorder treatment program must prepare for each client an individualized treatment plan that addresses the alcohol or substance use and co-occurring mental health disorders health affects on the client's major life areas.*~~ All clients receiving services must have an individualized service plan. The development of a ~~*treatment*~~ service plan must be a collaborative process involving the client~~, *family members,*~~ and other support and service systems. ~~*(5-1-10)*~~( )

02. ~~*Treatment*~~ Service Plan Based on a ~~*Biopsychosocial*~~ Comprehensive Assessment. The ~~*treatment*~~ service plan must be based on a Department-approved ~~*biopsychosocial*~~ comprehensive assessment~~ *of the client's alcohol or substance use disorders treatment needs, and contributions provided by the informal support system*~~. ~~*(5-1-10)*~~( )

03. Development and Implementation of the ~~*Treatment*~~ Service Plan. ~~*The assigned qualified substance use disorders professional staff member within a state approved program has overall responsibility for the development and implementation of the treatment plan.*~~ The responsibility for the development and implementation of the service plan will be assigned to a qualified staff member. ~~*(5-1-10)*~~( )

04. Timeline for Development of the ~~*Treatment*~~ Service Plan. A ~~*treatment*~~ service plan must be developed within seventy-two (72) hours following admission to an inpatient or residential facility. A ~~*treatment*~~ service plan must be developed within thirty (30) days of the completion or receipt of a state approved assessment in an outpatient setting. The ~~*treatment*~~ service plan must be reviewed and updated, as needed at least every seven (7) days in a residential setting and at least every ninety (90) days in an outpatient setting. ~~*(5-1-10)*~~( )

05. Content of the ~~*Treatment*~~ Service Plan. The individualized ~~*treatment*~~ service plan must include the following: ~~*(5-1-10)*~~( )

a. The services deemed clinically necessary to facilitate the client's alcohol and substance use disorders recovery; (5-1-10)

b. Referrals for needed ~~*adjunct services that the alcohol and substance use disorders treatment program does not provide*~~ services not provided by the program including referrals for

recovery support services that support treatment as defined in Subsection 012.03 of these rules. ~~(5-1-10)~~( )

~~**c.** *Referrals for recovery support services that support treatment as defined in Subsection 012.03 of these rules;* (5-1-10)~~

~~**d**~~**c.** Goals ~~*that the client must complete to reduce or eliminate alcohol or substance use and support recovery*~~ to achieve a recovery-oriented lifestyle; ~~(5-1-10)~~( )

~~**e**~~**d.** Objectives that relate to the goals, written in measurable terms, with targeted expected achievement dates; (5-1-10)

~~**f**~~**e.** Service frequency; (5-1-10)

~~**g**~~**f.** Criteria to be met for discharge from ~~*treatment*~~ service; ~~*and*~~ ~~(5-1-10)~~( )

g. A plan for services to be provided after discharge; ( )

~~**h**~~**h.** A plan for including the family or other social supports.~~;~~ ; and ~~(5-1-10)~~( )

i. Service plan goals and objectives that reflect the service needs identified on the assessment. ( )

~~***06. Integrated COD Treatment Plan Development.*** *In addition to the information in Section 380.05 of this section, the individualized treatment plan for a client with a co-occurring disorder must address the COD treatment and recovery support service needs of the client as identified in the current assessment. These additional items include the following:* (5-1-10)~~

~~***a.*** *A list of COD problems and needs identified during the assessment;* (5-1-10)~~

~~***b.*** *Overall goals to be achieved consistent with the client's treatment and recovery support services needs and assessment;* (5-1-10)~~

~~***c.*** *Reference to all services and contributions provided by the informal support system;* (5-1-10)~~

~~***d.*** *Documentation of who participated in the selection of services;* (5-1-10)~~

~~***e.*** *Documentation of unmet needs and service gaps;* (5-1-10)~~

~~***f.*** *References to any formal services arranged including specific providers;* (5-1-10)~~

~~***g.*** *Time frames for achievement of the treatment plan goals and objectives.* (5-1-10)~~

(BREAK IN CONTINUITY OF SECTIONS)

~~**386. DISCHARGE REQUIREMENTS.**~~
~~All alcohol and substance use disorders treatment programs must meet the discharge standards in these rules.~~ ~~(5-1-10)~~

~~**01. Discharge Plan**. A discharge plan must be jointly developed by the qualified substance use disorders professional and the client. This discharge plan includes the resources needed to support their recovery.~~ ~~(5-1-10)~~

~~**a.** The discharge plan must be initiated within forty-eight (48) hours of admission to a residential program and completed prior to the conclusion of substance use disorders treatment and recovery support services.~~ ~~(5-1-10)~~

~~**b.** The discharge plan must be initiated within thirty (30) days of admission to an outpatient program and completed prior to the conclusion of substance use disorders treatment and recovery support services.~~ ~~(5-1-10)~~

~~**c.** A hard copy of the discharge plan must be given to the client at the time of discharge from treatment.~~ ~~(5-1-10)~~

~~**d.** The discharge plan must include:~~ ~~(5-1-10)~~

~~i. The recovery support services and adjunct services to be continued after discharge including the location and contact information of existing appointments;~~ ~~(5-1-10)~~

~~ii. Information about accessing resources to maintain gains achieved while in treatment;~~ ~~(5-1-10)~~

~~iii. Identification of stressors that may led to a return to the use of alcohol or drugs and methods to address the stressors; and~~ ~~(5-1-10)~~

~~iv. Identification of person(s) to contact if additional services are needed.~~ ~~(5-1-10)~~

~~**02. Discharge Summary**. A discharge summary must be entered in the client record within fifteen (15) days following discharge.~~ ~~(5-1-10)~~

~~**a.** The discharge summary must include the results of the initial assessment and diagnosis.~~ ~~(5-1-10)~~

~~**b.** The discharge summary must include a clinical summary of the following:~~~~(5-1-10)~~

~~i. The course and progress of the client with regard to each identified clinical problem;~~ ~~(5-1-10)~~

~~ii. The clinical course of the client's treatment;~~ ~~(5-1-10)~~

~~iii. The final assessment, including the general observations and understanding of the client's condition initially, during treatment and at discharge; and~~ (5-1-10)

~~iv. The recommendations and arrangements for further treatment as described in the discharge plan.~~ (5-1-10)

38~~7~~6. -- 389. (RESERVED)

390. ENVIRONMENT REQUIREMENTS.
Each facility site of the program must have appropriate space, equipment and fixtures to meet the needs of clients. (5-1-10)

01. Fixtures and Equipment. Fixtures and equipment designated for each service must be constructed or modified in a manner that provides, insofar as possible, pleasant and functional areas that are accessible to all clients regardless of their disabilities. (5-1-10)

02. Office Space. Private space must be provided for personal consultation and counseling as well as family and group counseling sessions. All space for offices, storage, and supplies must be accessible. (5-1-10)

03. Equipment and Supplies. There must be equipment and supplies to meet the needs of the client at each facility. (5-1-10)

04. Safety, Fire, Health, and Sanitation Requirements. Space, equipment and facilities utilized by the program must meet federal, state and local requirements for safety, fire prevention, health and sanitation. (5-1-10)

05. Accessibility for Persons With Mobility and Sensory Impairments. For clients with mobility or sensory impairments, the facility must provide a physical environment which meets the needs of the person for independent mobility. New construction must meet the requirements of the American with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers under the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, reasonable accommodations. ~~The facility must provide the following:~~ ~~(5-1-10)~~( )

~~**a.** Ramps for clients who require assistance with ambulation must comply with the requirements of the ADAAG 4.8;~~ (5-1-10)

~~**b.** Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13;~~ (5-1-10)

~~**c.** Grab bars in toilet and bathrooms in compliance with ADAAG 4.26;~~ (5-1-10)

~~**d.** Toilet facilities in compliance with ADAAG 4.16 and 4.23;~~ (5-1-10)

~~**e.** Non-retractable faucet handles in compliance with ADAAG 4.19, with the exception of self closing valves under 4.19.5, and 4.27; and~~ (5-1-10)

~~*f. Suitable hand railing must be provided on both sides of all stairs leading into and out of a building for clients who require the use of crutches, walkers, or braces. (5-1-10)*~~

391. EMERGENCY PREPAREDNESS PLAN.
All alcohol and substance use disorders treatment or recovery support services programs must establish and maintain an Emergency Preparedness Plan designed to manage the consequences of natural disasters or other emergencies that could disrupt the program's ability to provide care. (5-1-10)

01. External and Internal Disasters. The program must have written policies and procedures to enable them to effectively prepare for both external and internal disasters that can negatively affect its environment of care. The policies and procedures must include: (5-1-10)

a. Communication plan for business hours and after hours; (5-1-10)

b. Clear chain of command which includes how to contact supervisors at all times; and (5-1-10)

c. Disaster orientation for all workers; (5-1-10)

~~***02. The Role as a Provider of Care to the Residents of Its Community**. The program must have written policies and procedures describing how the program is ready to assist as needed in case of community emergency, and as appropriate integrates its Emergency Preparedness Plan with community disaster plans to support the community's response to a disaster. (5-1-10)*~~

0~~3~~2. Interruption of Utility Services. Policies and Procedures must be written describing what action to be taken in the event of interruption of utility services, such as lighting, in order that staff can perform essential functions, back up computer data, and obtain urgent medical data to provide to a primary care physician; and (5-1-10)

0~~4~~3. Disruption of Services. Policies and procedures must be written describing what action will be taken in the event of disruption of services and management of space, supplies, communications, and security. (5-1-10)

392. MEDICAL EMERGENCY SERVICES.
All alcohol and substance use disorders treatment or recovery support services programs must have a written plan describing the manner in which medical emergency services must be accessed. (5-1-10)

01. Medical Emergency Services Policies and Procedures. The program must have written policies and procedures describing the type of medical emergency services available and the arrangements for referring or transferring clients to a medical facility. The policies and procedures must clearly specify the following: (5-1-10)

a. The staff of the program who are available and authorized to provide necessary emergency evaluations. (5-1-10)

b. The staff of the program who are authorized to arrange for clients to be referred or transferred to a medical facility. (5-1-10)

c. The arrangements the program has made for exchanging records with the medical facility when it is necessary for the care of the client. (5-1-10)

d. The location of the medical facility and the medical facilities contact information. (5-1-10)

e. The method of communication between the program and medical facility. (5-1-10)

f. The arrangements the program has made for transporting clients, when necessary, from the medical facility providing emergency services. (5-1-10)

g. Policies concerning notification of the client's family of emergencies and of arrangements that have been made for referring or transferring the client to another program or facility. (5-1-10)

02. Staff Training for Emergency Services. All staff must be trained in the emergency policies and procedures. (5-1-10)

03. CPR and Basic First Aid Training. A minimum of ~~O~~one (1) CPR/First Aid trained staff person must be onsite ~~*at all times*~~ during business hours. Staff responsible for ~~*CPR and First Aid*~~ client care must complete this training within ninety (90) days of employment. Additionally, the policies and procedures must establish the methods for renewal of CPR and first aid certification so that he remains current at all times. ~~*(5-1-10)*~~( )

04. Annual Review and Revisions. There must be documentation that the policies and procedures are reviewed at least annually and revised as necessary. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

399. PLANT TECHNOLOGY AND SAFETY MANAGEMENT.
Alcohol and substance use disorders treatment or recovery support services programs must meet applicable standards set forth in these rules. (5-1-10)

01. Buildings. Buildings on the premises in which services are delivered must be in compliance with the requirements of the local, state and federal codes concerning access, construction, fire and life safety that are applicable. (5-1-10)

a. Prior to initial occupancy and annually thereafter, the program's site(s) must be inspected for compliance with the Uniform Fire Code. Documentation of all findings, recommendations and corrective actions must be kept on file. (5-1-10)

b. Prior to initial occupancy and at the time of any structural change in a building, it must be inspected and found to be in compliance with local building codes. Written documentation of all findings, recommendations and corrective actions must be kept on file by the program. (5-1-10)

02. Grounds. The program grounds must be maintained in a manner that is designed to provide safe access in a safe environment for clients, personnel and visitors. (5-1-10)

a. The program must have specific plans and policies for the maintenance, supervision and safe use of all its grounds and equipment. (5-1-10)

b. The premises and all buildings must be kept free from the accumulation of weeds, trash and rubbish. (5-1-10)

03. General Safety. The program must have a plan that is designed to provide a safe environment for clients, personnel and visitors, and monitors that environment. (5-1-10)

a. There must be established procedures for the development, implementation and review of safety policies for all services. (5-1-10)

b. There must be a procedure for reporting, investigating and evaluating all accidents, injuries and safety hazards. The responses and follow-up actions are to be documented. (5-1-10)

c. Safety-related policies and procedures must be included in the orientation of all new employees and in the continuing education of all employees. (5-1-10)

04. Emergency Preparedness. There must be a plan for the protection of all persons in the event of a fire or other emergency. (5-1-10)

a. Each facility must develop and implement an emergency preparedness plan to follow in the event of fire, explosion, flood, earthquake, high wind, or other emergency. (5-1-10)

b. The facility must have written procedures outlining steps to be taken in the event of an emergency including: (5-1-10)

i. The individual(s) who is to respond; (5-1-10)

ii. Each person's responsibilities; (5-1-10)

iii. Where and how clients are to be evacuated; and (5-1-10)

iv. Notification of emergency agencies. (5-1-10)

c. All clients and employees must be advised of the actions required under emergency conditions. Diagrams of the building showing emergency protection areas and evacuation routes and exits must be conspicuously posted throughout the building. An outline of emergency instructions must be posted with the diagram. (5-1-10)

d. There must be a minimum of one (1) 2-A-10BC type fire extinguisher per floor, and if there is a kitchen on the floor, fire extinguisher must be in or immediately adjacent to the kitchen. Each extinguisher must be inspected annually by a fire extinguisher service agency. (5-1-10)

e. All exits must be marked with a lighted exit sign. (5-1-10)

f. There is a fire plan that includes the use and function of fire alarm and detection systems, containment and the protection of lives. (5-1-10)

i. Each work shift must have personnel trained and responsible for implementing the fire plan and the activation of the non-automatic components of the fire safety systems. (5-1-10)

ii. A minimum of one (1) fire drill must be held at least every thirty (30) days at unexpected times and under varying conditions to simulate unusual circumstances encountered in case of a fire. A record of drills must be maintained which includes the date and time of the drill, response of the personnel and clients, problems encountered and recommendations for improvements. (5-1-10)

iii. The alarm and detection system and any sprinkler system must be under the direct supervision of a staff member who must cause proper tests to be made at specified intervals and must have general charge of all alterations and additions. (5-1-10)

g. Program employees and clients must be provided with training about emergency preparedness policies and procedures. (5-1-10)

h. The emergency preparedness policies and procedures must be evaluated annually and updated as needed. (5-1-10)

05. Report of Fire. A separate report of each fire incident occurring within the program's facility must be submitted to the Department within twenty-four (24) hours of the occurrence. The “Facility Fire Incident Report,” will be issued to the Department to report specific information concerning date, origin, extent of damage, method of extinguishment and injuries, if any. (5-1-10)

06. Electrically Powered Equipment. The program must have procedures to assure that electrically powered, line-operated equipment is electrically safe. (5-1-10)

a. There must be a policy that identifies types of equipment that may pose an electrical hazard during intended use and outlines conditions of safe use. (5-1-10)

b. Policies for the use and control of personal electrical equipment must be developed and implemented. (5-1-10)

i. Clients must be apprised of the policies and procedures regarding use of personal electrical equipment upon admission to the program's facility. (5-1-10)

ii. Employees must be apprised of the policies and procedures regarding use of

personal electrical equipment upon employment. (5-1-10)

c. There must be a policy that outlines the action to be taken by staff to ensure client safety during a power outage. All staff must be trained in the procedure. (5-1-10)

07. Electrical Distribution. The program's facility must have an electrical distribution system that is designed, installed, operated, and maintained to provide electrical power for all required operations. (5-1-10)

a. There must be a schedule for preventive maintenance to assure that the electrical distribution system operates safely and reliably. (5-1-10)

b. Inspections and corrective actions must be documented. (5-1-10)

08. Heating, Ventilating and Air Conditioning. Where provided, the heating, ventilating, and air-conditioning (HVAC) system must be designed, installed, operated and maintained in a manner that provides a comfortable and safe environment for clients, personnel and visitors. (5-1-10)

09. Plumbing. The plumbing systems must be designed, installed, operated, and maintained in a manner that provides a safe supply of water for all required facility operations and facilitates the complete and safe removal of all storm water and waste water. The plumbing systems must comply with applicable local and state codes. (5-1-10)

10. Hazardous Materials and Wastes. The program must comply with applicable federal, state and local codes concerning hazardous materials and waste management. (5-1-10)

11. Boiler and Steam. Where provided, boiler systems must be installed, operated and maintained in a manner that is designed to provide a safe supply of steam or hot water for all required facility operations. (5-1-10)

12. Safety Devices and Practices. The program must have in place and maintain safety devices and operational practices to assure the safety of clients and personnel. (5-1-10)

a. Facility sites that do not have emergency medical care resources must have first aid kits. (5-1-10)

b. All staff must be familiar with the locations, contents, and use of the first aid kits. (5-1-10)

13. Smoking. Because smoking has been acknowledged to be a potential fire hazard, continuous efforts must be made to reduce such hazards in the facility. Written regulations governing the use of smoking materials must be adopted, conspicuously posted and made known to all program clients, staff members and the public. ~~*The written regulations must include at least the requirements listed below.*~~ Nothing in this section requires that smoking be permitted by programs whose admission policies prohibit smoking. ~~*(5-1-10)*~~( )

a. Designated areas must be assigned for client, staff, and public smoking. (5-1-10)

~~***b.*** *Noncombustible ashtrays of a safe design must be provided in all areas where smoking is permitted.* *(5-1-10)*~~

~~***c.*** *Metal containers with self-closing, tight-fitting lids or their equivalent must be provided in all areas where smoking is permitted. Containers must be twenty (20) feet from the entrance of the building.* *(5-1-10)*~~

~~***d***~~**b.** Tobacco products must not be used by children, adolescents, staff, volunteers, or visitors in any building used to house children or adolescents, or in the presence of children or adolescents, or in vehicles used to transport children or adolescents. (5-1-10)

14. Structure, Maintenance, Equipment to Assure Safety. The facility must be structurally sound, maintained, and equipped to assure the safety of clients, personnel, and the public including: (5-1-10)

a. Furnishings, decorations, or other objects cannot be placed so as to obstruct exit access or exits. (5-1-10)

b. All ramps, open porches, sidewalks, and open stairs must be maintained free of snow and ice buildup. (5-1-10)

c. Wood stoves must have railings or other protection designed to prevent residents from coming into contact with the stove surfaces. (5-1-10)

d. All fireplaces must have heat tempered glass fireplace enclosures or its equivalent. (5-1-10)

e. Boilers, hot water heaters, and unfired pressure vessels must be equipped with automatic pressure relief valves. (5-1-10)

f. Portable heating devices of any kind are prohibited; portable electric space heaters and moveable fuel-fired heaters are considered portable comfort heating devices. Exceptions: Heated mattress pads, electric blankets and heating pads when ordered by an authorized provider, physician. (5-1-10)

g. Flammable and highly combustible materials cannot be stored in the facility unless the building is protected throughout by an approved automatic fire extinguishing system. (5-1-10)

400. -- 449. (RESERVED)

Approved Facility and Program Services (Sections 450 through 454)

450. ADULT FACILITY AND PROGRAM SERVICES.

The following are adult facility and program services that may be approved by the Department: (5-1-10)

01. Assessment and Referral Services. (5-1-10)

02. Residential Social Detoxification Facility. (5-1-10)

03. Medically Monitored Inpatient Treatment. ( )

0~~3~~4. Clinically Managed Medium-Intensity Residential Treatment. (5-1-10)

0~~4~~5. Clinically Managed Low-Intensity Residential Treatment (Halfway House). (5-1-10)

0~~5~~6. Level I - Outpatient, and Level II.1 - Intensive Outpatient Treatment. (5-1-10)

0~~6~~7. Opioid Treatment Program. (5-1-10)

~~***07. Drug Court Outpatient Treatment Program.***~~ ~~*(5-1-10)*~~

08. Recovery Support Services. (5-1-10)

09. Early Intervention Services. (5-1-10)

451. CHILD AND ADOLESCENT FACILITY AND PROGRAM SERVICES.
The following are child and adolescent facility and program services that may be approved by the Department: (5-1-10)

01. Assessment and Referral Services. ( )

02. Medically Monitored Inpatient Treatment. ( )

0~~1~~3. Clinically Managed Medium-Intensity Residential Treatment. (5-1-10)

0~~2~~4. Level I - Outpatient, and Level II.1 - Intensive Outpatient Treatment. (5-1-10)

~~***03. Drug Court Outpatient Treatment Program.***~~ ~~*(5-1-10)*~~

0~~4~~5. Transitional Residential Treatment Services. (5-1-10)

0~~5~~6. Recovery Support Services. (5-1-10)

0~~6~~7. Early Intervention Services. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

453. SERVICES FOR WOMEN WITH DEPENDENT CHILDREN.

~~*These s*~~Services for pregnant women and women with dependent children including women who are attempting to regain custody of their children apply to all approved treatment facilities and programs seeking ~~*speciality*~~ status to provide services to pregnant women and women with dependent children. ~~*(5-1-10)*~~( )

01. Services. In addition to meeting all the rules and minimum standards contained in Sections 000 through 499 of these rules, each alcohol and substance use disorders treatment or recovery support services program seeking approval to provide services to pregnant women and women with dependent children must provide the following services, either directly or indirectly: ~~*(5-1-10)*~~( )

a. Primary Medical and Prenatal Care. Primary medical care, including prenatal care for women in treatment. (5-1-10)

b. Primary Pediatric Care. Primary pediatric care for the children of women in treatment, including immunizations. (5-1-10)

c. Gender Specific Treatment. Gender specific alcohol and substance use disorders treatment. (5-1-10)

d. Therapeutic Interventions for Women. Therapeutic interventions for women addressing issues such as relationships, sexual and physical abuse, and parenting. (5-1-10)

e. Therapeutic Interventions for Children. Therapeutic interventions for children in custody of women in treatment to address, among other things, developmental needs, sexual abuse, physical abuse, and neglect. (5-1-10)

f. Child Care. Child care while the women are receiving services. (5-1-10)

g. Treatment Provided as a Family Unit. Treating the family as a unit and therefore admit both women and their children into treatment, when appropriate. (5-1-10)

h. Case Management. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments, employment, and training programs. (5-1-10)

i. Education and Special Education Programs. Education and special education programs. (5-1-10)

j. Drug-free and Safe Housing. Drug-free and safe housing for women and their children. (5-1-10)

k. Childhood Programs. Therapeutic day care, Head Start, and other early childhood programs for children. (5-1-10)

l. Sexual Harassment Training. Curriculum that covers sexual harassment training for the clients. (5-1-10)

02. Written Agreements. Alcohol and substance use treatment or recovery support services programs that do not directly provide one (1) or more of the services described in Subsection 453.01 of these rules directly to women with dependent children must maintain written agreements with other approved programs that will be providing these services. A copy of the written agreements must be retained in the client's record. (5-1-10)

454. (RESERVED)

455. ~~CLINICAL CASE MANAGEMENT SERVICES~~ EMERGENCY DETOXIFICATION TREATMENT.

~~Clinical case management is the process in which a clinician is responsible for the direct care of a client and for coordinating other services needed by the client. In addition to meeting all the rules and minimum standards contained in Subsections 000 through 499 of these rules, each alcohol and substance use disorders treatment service program seeking approval as a clinical case management facility must meet the requirements in this rule. Clinical case management services include the following services.~~ Emergency detoxification treatment and medical treatment directly related thereto may be provided by a facility affiliated with or part of the medical service of a general hospital. ~~(5-1-10)~~( )

01. ~~Clinical Case Management Services~~ Place of Service Provision. Services must be provided in a hospital licensed under Title 39, Chapter 13, Idaho Code. ~~(5-1-10)~~( )

~~**a.** Services must include a full biopsychosocial assessment, utilizing a Department-approved assessment tool, and a case-management assessment of the client and client family strength and needs, service planning, linkage to other services, client advocacy, and monitoring service provisions. (5-1-10)~~

~~**b.** The facility must have policies and procedures for ensuring that multiple services are delivered in a coordinated and therapeutic manner to meet the goals of treatment outcomes. (5-1-10)~~

~~**c.** Clinical case management services must not duplicate case management, substance use disorder treatment, or service coordination services currently being provided under any other state-funded program. (5-1-10)~~

~~**d.** Clinical case management services provided must not exceed the clinician's scope of practice as defined by the individual licensing boards. (5-1-10)~~

02. ~~Eligibility Criteria~~ Range of Services Available. ~~To be eligible for clinical case management, the client must meet the following criteria:~~ The full range of services offered by the hospital must be available to the client. ~~(5-1-10)~~( )

~~**a.** Meet ASAM criteria for a substance use disorder and be unstable in two (2) or more of ASAM dimensions 1, 2, 5, or 6; (5-1-10)~~

~~**b.** Have a diagnosis of serious mental illness (SMI) as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR): schizophrenia; paranoia and other psychotic disorders; bipolar disorders~~

~~(mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders; and obsessive-compulsive disorders; and~~ ~~(5-1-10)~~

~~c. Be at risk for institutionalization.~~ ~~(5-1-10)~~

~~03. Clinical Case Manager Qualifications.~~ ~~(5-1-10)~~

~~a. A clinical case manager must be a Masters-level licensed clinician and be a qualified substance use disorders professional as defined in Section 013 of these rules.~~ ~~(5-1-10)~~

~~b. A clinical case manager may not hold trainee status.~~ ~~(5-1-10)~~

~~04. Caseload. A clinical case manager's total caseload must not be so large that it cannot assure quality service delivery and client satisfaction. For clinical case managers who have other recovery support service or treatment caseloads, or both, the total caseload must not exceed thirty (30) clients at any given time.~~ ~~(5-1-10)~~

~~05. Clinical Supervision. The clinical case management program must provide and document at least one (1) hour of clinical supervision per month for each clinical case manager.~~ ~~(5-1-10)~~

~~06. Limitations on Reimbursement.~~ ~~(5-1-10)~~

~~a. Clinical case managers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period.~~ ~~(5-1-10)~~

~~b. Clinical case managers may not bill the substance use disorders system for mental health services they provide.~~ ~~(5-1-10)~~

(BREAK IN CONTINUITY OF SECTIONS)

540. LEVEL III.1 - CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT FACILITY FOR ADULTS (HALFWAY HOUSE).

Each alcohol and substance use disorders treatment program seeking approval as a Level III.1 - Clinically Managed Low Intensity Residential Treatment Facility (Level III.1) must meet the requirements in Section 540 of these rules, in addition to all rules and minimum standards contained in Sections 000 through 499. (5-1-10)

01. Treatment Services for Adults Level III.1. (5-1-10)

a. A Level III.1 treatment facility provides living accommodations in a structured environment that encourages each adult client to assume responsibility for their own rehabilitation. (5-1-10)

b. Treatment and adjunct services may be provided on-site or arranged for by the

program. If the program chooses to provide treatment services on-site, it must also meet the requirements in Section 600 of these rules. (5-1-10)

c. A Level III.1 treatment facility must ~~*encourage use of*~~ provide information regarding community resources ~~*by*~~ to persons recovering from alcohol and substance use disorders. ~~*(5-1-10)*~~( )

d. There must be written provisions for medical screening, care of clients requiring minor treatment or first aid and handling of medical emergencies. (5-1-10)

02. Supervision for Adults Level III.1. A Level III.1 treatment facility must be supervised by a qualified substance use disorders professional. Section 215 of these rules does not apply to this level of care in this setting. (5-1-10)

03. Staffing for Adults Level III.1. A staff person must be available to residents twenty-four (24) hours per day, seven (7) days a week. The staff to client ratio must not exceed twelve (12) clients to one (1) staff person. The staff must be composed of: (5-1-10)

a. A house manager; and (5-1-10)

b. Other staff sufficient to meet the required staff to client ratio. (5-1-10)

541. -- 599. (RESERVED)

Alcohol and Substance Use Disorders Outpatient Treatment Component Services (Sections 600 through 699)

600. LEVEL I - OUTPATIENT, AND LEVEL II.1 - INTENSIVE OUTPATIENT TREATMENT FACILITIES FOR CHILDREN, ADOLESCENTS, AND ADULTS.
Each alcohol and substance use disorders treatment program seeking approval as a Level I - Outpatient Treatment Facility (Level I), or a Level II.1 - Intensive Outpatient Treatment Facility (Level II.1), must meet the requirements in Section 600 of these rules, in addition to all rules and minimum standards contained in Sections 000 through 499 of these rules. (5-1-10)

01. Treatment Services in Level I, and Level II.1. (5-1-10)

a. Services in outpatient facilities must be provided at specified times. (5-1-10)

b. Counseling services must be provided through the outpatient program on an individual, family, or group basis. (5-1-10)

c. The services must include educational instruction and written materials on the nature and effects of alcohol and substance use disorders and the recovery process. (5-1-10)

d. The program must provide adjunct services or refer the client to adjunct services as indicated by client need. (5-1-10)

02. Supervision in Level I, and Level II.1. The program must provide supervisory staff as described in Section 215 of these rules. (5-1-10)

03. Staffing in Level I, and Level II.1. There must be qualified staff to maintain appropriate staff to client ratios. (5-1-10)

a. Level I must employ at a minimum one (1) qualified substance use disorders professional staff person for every fifty (50) clients. Irrespective of whether the caseload is private or publicly funded, the maximum caseload for one (1) qualified substance use disorders professional is fifty (50) clients. (5-1-10)

b. Level II.I must employ at a minimum one (1) qualified substance use disorders professional staff person for every thirty (30) clients. Irrespective of whether the caseload is private or publicly funded, the maximum caseload for one (1) qualified substance use disorders professional is fifty (50) clients. (5-1-10)

04. Treatment Service Delivery Settings Offsite in Levels I and II.1. Provision of outpatient treatment services outside of an approved facility: (5-1-10)

a. Services must be provided by qualified substance use disorders professionals. (5-1-10)

b. Services must be provided in a city, county, state or federally approved institution or client's residence. ~~*(5-1-10)*~~( )

c. Services must be provided in a safe setting. (5-1-10)

d. Confidentiality according to 42 CFR and HIPAA regulations must be adhered to. (5-1-10)

e. Client records must be maintained in accordance to Sections 375 and 376 of these rules. (5-1-10)

f. Individual client needs, as reflected in the ~~*treatment*~~ service plan, indicate the need or appropriateness of providing treatment outside the approved facility. ~~*(5-1-10)*~~( )

g. The Department has final authority over the decision of whether a site meets Subsections 600.04.a. through 600.04.f. of these rules. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

611. -- ~~***619. (RESERVED)***~~

~~***620. DRUG COURT OUTPATIENT TREATMENT PROGRAM.***~~

Each alcohol and substance use disorders treatment program seeking approval as a drug court outpatient treatment program must meet the requirements in Sections 620 through 622 of these rules, in addition to all rules and minimum standards contained in Sections 000 through 499 of these rules. *(5-1-10)*

01. Governing Body for a Drug Court Outpatient Treatment Program. *A drug court outpatient treatment program must have a governing body, which can be the local Drug Court Board.* *(5-1-10)*

a. *The governing body must develop a written mission statement, goals, and objectives that establish the drug court outpatient treatment program's philosophy and direction for treatment services.* *(5-1-10)*

b. *The governing body must establish bylaws and administrative policies to guide relationships between itself and the responsible administrative and professional staffs and the community. Current copies of the bylaws and administrative policies must be readily available to all members of the governing body, the Department, and other persons in accordance with their responsibilities or involvement in implementing the policies of the drug court outpatient treatment program.* *(5-1-10)*

02. Assessment and Participation Policies and Procedures for a Drug Court Outpatient Treatment Program. *The local Drug Court Board and State Drug Court Coordinating Committee are responsible for developing policies and procedures for assessment and participation in a drug court outpatient treatment program.* *(5-1-10)*

03. Admissions and Discharge Policies and Procedures for a Drug Court Outpatient Treatment Program. *The local Drug Court Board is responsible for developing policies and procedures governing the treatment admissions process which must include use of eligibility guidelines, the LSI-R, substance use disorder assessments, program capacity, acceptance, and appropriateness for treatment. The Board is also responsible for developing policies and procedures governing the treatment discharge process.* *(5-1-10)*

621. DRUG COURT OUTPATIENT TREATMENT PROGRAM REQUIREMENTS.

01. Staff Composition in a Drug Court Outpatient Treatment Program. *The drug court outpatient treatment program must have a sufficient number of treatment staff, qualified substance use disorders professionals, and administrative and support staff to provide for the care and treatment of clients.* *(5-1-10)*

a. *Unless otherwise specified, programs providing treatment services must provide for the following supervisory staff:* *(5-1-10)*

i. *The program must provide for a Program Administrator who is responsible for oversight of all services provided by the program.* *(5-1-10)*

ii. *The program must provide for a Treatment Supervisor to provide on-site supervision at the treatment facility. The individual may supervise more than one (1) treatment activity. This position can also be the Clinical Supervisor, Program Administrator, or both. In*

~~those instances where these positions are combined, requirements must be met for all positions.~~ ~~(5-1-10)~~

~~iii. The program must provide for a Clinical Supervisor who can be the same individual or position as the Program Administrator, Treatment Supervisor, or both. In those instances where these positions are combined, all requirements must be met for all positions. The Clinical Supervisor can be a single individual who will provide for statewide oversight of clinical activities but need not provide direct clinical supervision of staff.~~ ~~(5-1-10)~~

~~**b.** Supervisory staff, which includes the Program Administrator, Treatment Supervisor, and Clinical Supervisor, must meet the qualifications listed in Section 215 of these rules.~~ ~~(5-1-10)~~

~~**c.** The drug court treatment program must provide supervision as follows:~~ ~~(5-1-10)~~

~~i. Qualified substance use disorders professionals must supervise all treatment activities.~~ ~~(5-1-10)~~

~~ii. Procedures for supervision of all clinical activities must be established which specify frequency and type of supervisory contact, and periodic client file reviews.~~ ~~(5-1-10)~~

~~**d.** There must be qualified staff to maintain appropriate staff to client ratios as set by the State Drug Court Coordinating Committee, and staff to provide necessary support to the professional staff.~~ ~~(5-1-10)~~

~~**e.** The program must employ at least one (1) qualified substance use disorders professional for each facility; or~~ ~~(5-1-10)~~

~~i. If the program arranges for the provision of counseling services, it must maintain a valid written agreement or contract with a qualified substance use disorders professional.~~ ~~(5-1-10)~~

~~ii. When a qualified substance use disorders professional is not available or needed on a full-time basis, arrangements must be made to obtain a qualified substance use disorders professional on an attending, continuing consultative, or part-time basis.~~ ~~(5-1-10)~~

~~**02. Policies and Procedures for Drug Court Client Expectations**. Drug court outpatient treatment programs must have written policies and procedures that specify client expectations of drug court outpatient treatment program including:~~ ~~(5-1-10)~~

~~**a.** Impartial access to treatment regardless of race, creed, color, religion, age, gender, national origin, veteran, or disability that does not preclude participation in the alcohol and substance use disorders treatment program;~~ ~~(5-1-10)~~

~~**b.** Respect for personal dignity in the provision of all care and treatment;~~ ~~(5-1-10)~~

~~**c.** Humane services, regardless of the source of financial support;~~ ~~(5-1-10)~~

~~d. An individualized treatment plan, based on assessment of current needs; (5-1-10)~~

~~e. Client access to their treatment plan; and (5-1-10)~~

~~f. What information will be shared and the nature of communications with members of the local drug court team. (5-1-10)~~

~~03. Client to be Informed of Expectations in a Drug Court Outpatient Treatment Program. The drug court outpatient treatment program must inform each client of the drug court client expectations. The client must sign a written statement of drug court client expectations that includes who the client may contact with questions, concerns, or complaints regarding services provided. (5-1-10)~~

~~622. DRUG COURT OUTPATIENT TREATMENT PLAN AND SERVICES.~~

~~01. Individualized Treatment Plan in a Drug Court Outpatient Treatment Program. The drug court outpatient treatment program must have a written, individualized treatment plan for each client that addresses the alcohol and substance use disorders affects on the major life areas and is based on assessment of the client's clinical and criminogenic needs. (5-1-10)~~

~~a. Overall responsibility for development and implementation of the treatment plan must be assigned to a qualified substance use disorders professional staff member. (5-1-10)~~

~~b. Beginning with the completion of the assessment process, and within time frames set by the local Drug Court Board, a detailed individualized treatment plan must be developed which meets the following requirements: (5-1-10)~~

~~i. Specifies the services necessary to meet the client's needs; (5-1-10)~~

~~ii. Includes referrals for needed services that the program does not provide; (5-1-10)~~

~~iii. Contains specific goals that the client must achieve to reduce or eliminate alcohol or drug use; (5-1-10)~~

~~iv. Contains specific objectives that relate to the goals, are written in measurable terms and includes expected achievement dates; and (5-1-10)~~

~~v. Specifies the frequency of treatments. (5-1-10)~~

~~c. When appropriate, the client must participate in the development of the treatment plan and such participation must be documented in the client's record. (5-1-10)~~

~~d. A specific plan for involving the family or significant others must be included when indicated. (5-1-10)~~

~~02. Treatment Services Provided in a Drug Court Outpatient Treatment Program. (5-1-10)~~

~~**a.** *Services in outpatient facilities must be provided at specified times.* (5-1-10)~~

~~**b.** *Counseling services must be provided through the outpatient program on an individual, family, or group basis.* (5-1-10)~~

~~**c.** *The services must include educational instruction and written materials on the nature and effects of substance use disorders and the recovery process, as well as cognitive behavioral interventions to address the identified criminogenic needs. Assessments must include the use of the LSI-R.* (5-1-10)~~

~~**d.** *The program must provide adjunct services or refer the client to adjunct services as indicated by client need.* (5-1-10)~~

~~**e.** *Requirements for group treatment must be present for the effective delivery of education, skill training, and process groups, and must specify the maximum number of participants allowed for each type of group.* (5-1-10)~~

~~*623.*~~ **629. (RESERVED)**

630. CHILD AND ADOLESCENT TRANSITIONAL RESIDENTIAL TREATMENT FACILITY.
Each alcohol and substance use disorders treatment program seeking approval as a Child and Adolescent Transitional Residential Treatment Facility must meet the requirements in Section 630 of these rules, in addition to all rules and minimum standards contained in Sections 000 through 499 of these rules. (5-1-10)

01. Licensing of a Child and Adolescent Residential Transitional Facility. A Child and Adolescent Residential Transitional Facility must meet the requirements in IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing," and be licensed annually as a Children's Residential Care Facility. (5-1-10)

02. Treatment Services in a Child and Adolescent Residential Transitional Facility. (5-1-10)

a. Child and Adolescent Transitional Residential Treatment will be provided as a Level III.1 - Clinically Managed Low-Intensity Residential Service, which may include outpatient for clients who have completed Level III.5, Section 520, and lack supportive recovery environments. (5-1-10)

b. A Level III.1 facility provides living accommodations in a structured environment that encourages each child and adolescent client to assume responsibility for their own rehabilitation. (5-1-10)

c. Treatment and adjunct services ~~*must not be provided but can be arranged for by the program*~~ may be provided on-site or arranged for by the program. If the program chooses to provide treatment services on-site, it must also meet the requirements in Section 600 of these rules. ~~(5-1-10)~~( )

d. A Level III.1 treatment facility must ~~*encourage use of*~~ provide information regarding community resources ~~*by*~~ to persons recovering from alcohol and substance use disorders. ~~*(5-1-10)*~~( )

e. Treatment under Level III.1 is directed toward applying recovery skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery, and reintegrating the individual into the worlds of school, work and family life. (5-1-10)

03. Case Management in a Child and Adolescent Residential Transitional Facility. Every Child and Adolescent Transitional Residential Treatment Facility must provide case management and meet the requirements set forth in Section 745 of these rules. (5-1-10)

631. -- 639. (RESERVED)

640. LEVEL .5 - EARLY INTERVENTION SERVICES FOR CHILDREN AND ADOLESCENTS.
Early intervention is a brief intensive service that is delivered in an approved treatment facility. (5-1-10)

01. Services in Child and Adolescent Level .5. Services must be provided by a qualified substance use disorders professional. (5-1-10)

02. Case Management in Child and Adolescent Level .5. Case Management may be provided as set forth in Section 745 of these rules. (5-1-10)

03. Individualized Intervention Plan in Child and Adolescent Level .5. The intervention program must prepare for each client an intervention plan that addresses the service needs of the client as identified in the current assessment. To the maximum extent possible, the development of the intervention plan must be a collaborative process involving the client~~*, family members,*~~ and other support/service systems. A written intervention plan must be developed and implemented within fifteen (15) days of initiation of services. The intervention plan must be updated at least every ninety (90) days. The individualized intervention plan must contain at least the following: ~~*(5-1-10)*~~( )

a. A list of problems describing areas of concern, and needs identified during the assessment; (5-1-10)

b. Overall goals, describing desired results to be achieved, consistent with the client's service needs and assessment; (5-1-10)

c. Identification of the nature, amount, frequency, and duration of the intervention services required by the client; (5-1-10)

d. Selection of the nature, amount, type, frequency, and duration of services will be determined with the participation of the client, the client's informal support network, and providers of services; (5-1-10)

e. Documentation of who participated in the selection of services; (5-1-10)

f. Documentation of unmet needs and service gaps; (5-1-10)

g. Concrete measurable goals, objectives, and interventions; ~~*and*~~ ~~*(5-1-10)*~~( )

h. Time frames for achievement of the case management goals and objectives.~~:~~; and ~~*(5-1-10)*~~( )

i. A plan for services to be provided after discharge. ( )

04. Education in Child and Adolescent Level .5. All providers must utilize an evidence based education program from the Department's list of approved programs. (5-1-10)

05. Counseling in Child and Adolescent Level .5. Each program will provide individual and group counseling to support client's abstinence. (5-1-10)

06. Discharge from Child and Adolescent Level .5. Discharge is upon successful completion of the intervention plan or therapeutic discharge. (5-1-10)

~~***07. Discharge Plan in Child and Adolescent Level .5**. Each client must participate in the development of a discharge plan as described in Section 386 of these rules.* *(5-1-10)***~~

0~~8~~7. Client Intervention Services in Child and Adolescent Level .5. Clients in intervention services are to be served separately from clients in other levels of care. (5-1-10)

641. -- 649. (RESERVED)

650. LEVEL .5 - EARLY INTERVENTION SERVICES FOR ADULTS.
Early intervention is a brief intensive service that is delivered in an approved treatment facility. (5-1-10)

01. Case Management in Adult Level .5. Case Management may be provided as set forth in Section 745 of these rules. (5-1-10)

02. Individualized Intervention Plan in Adult Level .5. The intervention program must prepare for each client an intervention plan that addresses the service needs of the client as identified in the current assessment. To the maximum extent possible, the development of the intervention plan must be a collaborative process involving the client~~*, family members,*~~ and other support/service systems. A written intervention plan must be developed and implemented within fifteen (15) days of initiation of services. The intervention plan must be updated at least every ninety (90) days. The individualized intervention plan must contain at least the following: ~~*(5-1-10)*~~( )

a. A list of problems describing areas of concern, and needs identified during the assessment; (5-1-10)

b. Overall goals, describing desired results to be achieved, consistent with the client's

service needs and assessment; (5-1-10)

c. Identification of the nature, amount, frequency, and duration of the intervention services required by the client; (5-1-10)

d. Selection of the nature, amount, type, frequency, and duration of services will be determined with the participation of the client, the client's informal support network, and providers of services; (5-1-10)

e. Documentation of who participated in the selection of services; (5-1-10)

f. Documentation of unmet needs and service gaps; (5-1-10)

g. Concrete measurable goals, objectives, and interventions; and (5-1-10)

h. Time frames for achievement of the case management goals and objectives. (5-1-10)

i. A plan for services to be provided after discharge. ( )

03. Education in Adult Level .5. All providers must utilize an evidence based education program from the Department's list of approved programs. (5-1-10)

04. Counseling in Adult Level .5. Each program will provide individual and group counseling to support client's abstinence. (5-1-10)

05. Discharge in Adult Level .5. Discharge is upon successful completion of the intervention plan or therapeutic discharge. (5-1-10)

06. Clients in Intervention Services in Adult Level .5. Clients in intervention services are to be served separately from clients in other levels of care. (5-1-10)

~~***07. Discharge Plan in Adult Level .5**. Each client must participate in the development of a discharge plan as described in Section 386 of these rules.* (5-1-10)~~

651. -- 699. (RESERVED)

Recovery Support Component Services
(Sections 700 through 799)

700. ADULT STAFFED SAFE AND SOBER HOUSING FACILITY.
Each alcohol and substance use disorders treatment or recovery support services program seeking approval as an Adult Staffed Safe and Sober Housing facility must meet the requirements in Section 700 of these rules, in addition to Sections 000 through 499 of these rules, unless otherwise specified in this section. (5-1-10)

01. Services in an Adult Staffed Safe and Sober Housing Facility. (5-1-10)

a. Adult Staffed Safe and Sober Housing facilities provide a safe, clean, and sober environment for clients who are transitioning back into the community. (5-1-10)

b. There must be written policies and procedures that establish house rules and requirements and include procedures for monitoring client compliance and consequences for violating house rules and requirements. (5-1-10)

c. Adult Staffed Safe and Sober Housing programs must allow clients to participate in daily living activities, physical activities, and leisure time activities. Section 224 of these rules does not apply to this level of care in this setting. (5-1-10)

d. Adult Staffed Safe and Sober housing facilities must ~~*encourage use of*~~ provide information regarding community resources ~~*by*~~ to persons recovering from alcohol and substance use disorders. Sections 370 and 380 of these rules do not apply to this level of care in this setting. ~~*(5-1-10)*~~( )

02. Program Fees for Expenses in an Adult Staffed Safe and Sober Housing Facility. (5-1-10)

a. An Adult Staffed Safe and Sober Housing facility must not bill rent to clients receiving state substance use disorders funding for housing but may impose a "program fee" to cover the following expenses: (5-1-10)

i. Basic utilities-electricity, gas, water, sewer, trash, etc.; (5-1-10)

ii Telephone service; (5-1-10)

iii Cable or satellite television; (5-1-10)

iv. Internet services, if available to client; (5-1-10)

v. Amenities fund covers wear and tear on home living items such as furniture, bedding, curtains, washer and dryer, cookware, dishes, appliances, etc.; (5-1-10)

vi. Cleaning supplies, if supplied by provider; (5-1-10)

b. Program fees must not exceed one hundred dollars ($100) per month. (5-1-10)

c. Program fees must be imposed equally on residents receiving state funding for housing and non-state funded residents. (5-1-10)

d. Adult Staffed Safe and Sober Housing facilities must assure that clients fully understand the purpose of an imposed program fee and what it includes. (5-1-10)

e. Adult Staffed Safe and Sober Housing facilities must disclose to the Department any program fees imposed and what is included in the fee. Changes to program fees must be reported to the Department prior to being imposed. (5-1-10)

f. The client, client's guardian, or conservator must be notified in writing of an increase in the program fee at least thirty (30) calendar days prior to such a raise taking effect. (5-1-10)

03. Termination of Housing from an Adult Staffed Safe and Sober Housing Facility. ~~*Section 386 of these rules does not apply to this subsection.*~~ The housing provider may discharge a client who violates house rules and requirements in accordance with the following: ~~*(5-1-10)*~~( )

a. Client is informed verbally and in writing of reasons for discharge; (5-1-10)

b. A process is in place that recognizes the rights of the client to due process and allows the client to request a formal review of the decision; (5-1-10)

c. The reasons for discharge and any actions following are clearly documented in the client's file. (5-1-10)

04. Staffing in an Adult Staffed Safe and Sober Housing Facility. A staff person must be available to residents twenty-four (24) hours per day, seven (7) days a week, and conduct daily site visits. Sections 215 through 218 of these rules does not apply to this level of care in this setting. At a minimum, the staff must include: (5-1-10)

a. A house manager who is on-site a minimum of twenty (20) hours a week; or (5-1-10)

b. A housing coordinator who is off-site, but monitors house activities on a daily basis. (5-1-10)

05. Staff Qualifications for an Adult Staffed Safe and Sober Housing Facility. A house manager and housing coordinator must have at least one (1) year of experience or training working with the substance use disorders clients. (5-1-10)

06. Certified Home Inspection in an Adult Staffed Safe and Sober Housing Facility. An Adult Staffed Safe and Sober Housing program must provide a certified home inspection in addition to the required fire inspection documentation. There must be documentation that any major health and safety issues identified in the certified home inspection have been corrected. (5-1-10)

07. Living Environment in an Adult Staffed Safe and Sober Housing Facility. Adult Staffed Safe and Sober Housing facilities must meet the requirements set forth in Section 396 of these rules. (5-1-10)

08. Facility Inspection of an Adult Staffed Safe and Sober Housing Facility. Adult Staffed Safe and Sober Housing facilities must be inspected by staff a minimum of three (3) times a week to determine if hazards or potential safety issues exist. A record of the inspection must be maintained that includes the date and time of the inspection, problems encountered, and recommendation for improvement. (5-1-10)

09. Fire Inspection of an Adult Staffed Safe and Sober Housing Facility. An Adult Staffed Safe and Sober Housing facility must provide documentation of a fire safety inspection conducted annually by the State Fire Marshall or designee. (5-1-10)

701. CHILD AND ADOLESCENT STAFFED SAFE AND SOBER HOUSING FACILITY.
Each alcohol and substance use disorders treatment or recovery support services program seeking approval as a Child and Adolescent Staffed Safe and Sober Housing facility must meet the requirements in this rule in addition to Sections 000 through 499 of these rules, unless otherwise specified in this rule. ( )

01. Licensing of a Child and Adolescent Staffed Safe and Sober Housing Facility. A Child and Adolescent Staffed Safe and Sober Housing Facility must meet the requirements in IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing," and be licensed annually as a Children's Residential Care Facility. ( )

02. Admission Criteria for Child and Adolescent Staffed Safe and Sober Housing. Individuals must be admitted to a Child and Adolescent Staffed Safe and Sober Housing facility prior to their 18th (eighteen) birthday. An individual may be eligible for continued care but must meet requirements set forth in IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing," Sections 530 and 531. A child or adolescent must meet one of the following for admission to a Child and Adolescent Staffed Safe and Sober Housing facility: ( )

a. The Child or Adolescent has completed a level III.5 residential substance use disorders treatment program and is in need of a step down program with less intensive clinical needs but a continued need for both the client and the family to prepare for and ensure the child or adolescent's safe and effective return home; ( )

b. The Child or Adolescent is re-entering the community from either a state run correctional facility or county detention with a verifiable substance use disorder and is unable to return home due to an unsupportive recovery environment; ( )

c. The Child or Adolescent is unable to function in their home due to an unsupportive recovery environment but has less intensive clinical needs than those provided in a Level III.5 program. ( )

03. Services in a Child and Adolescent Staffed Safe and Sober Housing Facility. ( )

a. Child and Adolescent Staffed Safe and Sober Housing will be provided as a Recovery Support Service and includes housing, meals and supervision. ( )

b. A Child and Adolescent Staffed Safe and Sober Housing Facility may provide or arrange for outpatient treatment services to be delivered if the child or adolescent meets criteria for these services. If the program chooses to provide treatment services on-site, it must also meet the requirements in Section 600 of these rules. ( )

c. A Child and Adolescent Staffed Safe and Sober Housing Facility must provide information regarding recovery support services and community resources to assist the child or adolescent in maintaining a supportive recovery lifestyle. ( )

d. The Child or Adolescent must have access to transportation services as defined in Section 730 of this rule. ( )

e. Services under Child and Adolescent Staffed Safe and Sober Housing are directed toward applying recovery skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery, and reintegrating the individual into the worlds of school, work and family life and/or preparing for independent living. ( )

04. Living Environment in a Child and Adolescent Staffed Safe and Sober Housing Facility. A Child and Adolescent Staffed Safe and Sober Housing Facility must meet the requirements set forth in Section 396 of these rules, in addition to the following: ( )

a. A Child and Adolescent Staffed Safe and Sober Housing Facility provides a safe, clean, supportive and sober environment for children and adolescents transitioning back into the community. ( )

b. A Child and Adolescent Staffed Safe and Sober Housing Facility provide living accommodations in a structured environment that encourages each child and adolescent to assume responsibility for their own rehabilitation. ( )

c. A Child and Adolescent Staffed Safe and Sober Housing Facility must allow children and adolescents to participate in daily living activities, physical activities, and leisure time activities. ( )

d. There must be written policies and procedures that establish house rules and requirements and include procedures for monitoring client compliance and consequences for violating house rules and requirements. ( )

701~~1~~2. -- 709. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

720. LIFE SKILLS.
Each alcohol and substance use disorders treatment or recovery support services program seeking approval as Life Skills provider must meet the requirements in Section 720 of these rules, in addition to Sections 000 through 499 of these rules, unless otherwise specified in these rules.
(5-1-10)

01. Services in a Life Skills Program. Life Skills programs are non-clinical services designed to enhance personal and family skills for work and home, reduce marriage and family

conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community. (5-1-10)

a. Services may be provided on an individual basis or in a group setting and can include activities that are culturally, spiritually, or gender-specific. Sections 370~~,~~ and 380~~, *and 386*~~ of these rules do not apply to this setting. ~~*(5-1-10)*~~( )

b. Services provided must be billable only as a recovery support service. ( )

~~***b***~~**c.** Life Skills programs must have a written plan. This written plan must include the curriculum used. Section 224 of these rules does not apply to this setting. The list of activities must include: (5-1-10)

i. A description of each activity; (5-1-10)

ii. The measurable goals of each activity; and (5-1-10)

iii. The staff person responsible for providing or supervising each activity. (5-1-10)

~~***c.** Life Skills may be approved for clinical treatment providers on a case-by-case basis under the following conditions:* *(5-1-10)*~~

~~***i.** The service is billable only as a recovery support service; and* *(5-1-10)*~~

~~***ii.** The service is distinguishable from treatment services.* *(5-1-10)*~~

~~***iii.** Clients receiving individual services from a qualified substance use disorders professional must be included in the staff-to-client ratio counts required for treatment services.* *(5-1-10)*~~

02. Supervision in a Life Skills Program. The program must provide staff with supervision to ensure that services are provided effectively and appropriately. Sections 215 through 218 of these rules do not apply to this setting. (5-1-10)

03. Staffing and Documentation in a Life Skills Program. Each Life Skills program must ensure services are provided by qualified staff who meet the following requirements: ~~*(5-1-10)*~~( )

a. Each staff person has completed training ~~*to deliver the service or has a record of performance in the provision of service of*~~ or has at least one (1) year experience delivering the life skill service; ~~*(5-1-10)*~~( )

b. Personnel file must contain documentation that each staff person ~~*is qualified*~~ meets requirements under Subsection 720.03.a. of this rule; ~~*(5-1-10)*~~( )

c. There must be one (1) qualified staff person for every thirty (30) clients in a group setting; and (5-1-10)

d. ~~*The total client caseload of any qualified staff person must not exceed forty-five (45) clients.*~~ Clients receiving individual services from a qualified substance use disorders professional must be included in the staff-to-client ratio counts required for treatment services. ~~*(5-1-10)*~~( )

721. -- 729. (RESERVED)

730. TRANSPORTATION SERVICES.
Each alcohol and substance use disorders treatment or recovery support services program seeking approval as a transportation provider must meet the requirements in Section 730 of these rules, in addition to Sections 000 through 499 of these rules, unless otherwise specified in this section. (5-1-10)

01. Transportation Services. Transportation services are provided to clients who are engaged in alcohol and substance use disorders treatment or recovery support services, or both, and who have no other means of obtaining transportation. Reimbursement is not available for transportation services to and from employment. Sections 215, 216, 217, 218, 224, 370, 380, and 386 of these rules do not apply to this setting. Transportation services include any of the following types of transportation: (5-1-10)

a. Public Transportation. Any entity in the business of transportation that is organized to provide and actually provides transportation to the general public. (5-1-10)

b. Individual Transportation. Individual transportation is any individual providing transportation who does not meet the definition of public or Agency Transportation and provides only transportation services to an eligible client. Only individual transportation providers who are approved by the ~~*Bureau of*~~ Substance Use Disorders Program can be reimbursed. ~~*(5-1-10)*~~( )

c. Agency Transportation. Agency transportation is an entity whose employees or agents provide transportation services in addition to one (1) or more other services to the same eligible client. (5-1-10)

02. ~~*Programs Seeking*~~ Approval for Transportation Services. Programs seeking approval for transportation services must meet the following requirements: ~~*(5-1-10)*~~( )

a. Agencies must maintain documentation of a valid driver's license for each employee who transports clients; (5-1-10)

b. The program must adhere to all laws, rules, and regulations applicable to drivers and type of vehicles used; (5-1-10)

c. The minimum insurance required for all programs is professional liability, commercial general liability, and comprehensive liability for all program vehicles. All facilities must maintain professional liability insurance in the amount of at least five hundred-thousand to one million dollars ($500,000/$1,000,000) and general liability and automobile insurance in the amount of at least one million to three million dollars ($1,000,000/$3,000,000). Copies of the declarations face-sheet for all policies must be included with the application. Individual providers

must carry at least the minimum insurance required by Idaho law. If an agency permits employees to transport clients in employee's personal vehicles, the agency must ensure that insurance coverage is carried to cover those circumstances. (5-1-10)

d. The program must document that the person for whom services are billed was actually transported for all the distance billed. (5-1-10)

~~***e.*** *Transportation is paid on a reimbursement basis only.* ***(5-1-10)***~~

~~***f***~~**e.** Only the least expensive, most appropriate means of transportation will be authorized. (5-1-10)

~~***g***~~**f.** Transportation providers must provide the following services and perform the following tasks: (5-1-10)

i. Provide services to transport clients to and from alcohol and substance use disorders treatment or ~~*recovery support*~~ services needed to support recovery; ~~***(5-1-10)***~~( )

ii. Provide services at a time and location that is suitable for the client to attend alcohol and substance use disorders treatment or ~~*recovery support*~~ services needed to support recovery; and ~~***(5-1-10)***~~( )

~~***h***~~**g.** The program must provide transportation by the most direct route practical. (5-1-10)

~~***i***~~**h.** Each transportation program must ensure the safety and well-being of all clients transported. This includes maintaining and operating vehicles in a manner that ensures protection of the health and safety of the clients transported. The transportation program must meet the following requirements: (5-1-10)

i. The driver is prohibited from using a cell phone while transporting a client; (5-1-10)

ii. No smoking in the vehicle; (5-1-10)

iii. All vehicles must be equipped with a first aid kit and fire extinguisher; and (5-1-10)

iv. The vehicle must be equipped with appropriate restraints. (5-1-10)

03. Staffing for Transportation Services. The operator of a motor vehicle transporting clients must be, at a minimum, eighteen (18) years of age. (5-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

745. ~~*BASIC AND INTENSIVE*~~ CASE MANAGEMENT SERVICES.
In addition to meeting all the rules and minimum standards contained in Sections 000 through 499 of these rules, each alcohol and substance use disorders treatment or recovery support services program seeking approval as a ~~*Basic or Intensive*~~ case management ~~*facility*~~ provider must meet the requirements in Section 745 of these rules. ~~*Basic and Intensive c*~~Case management services include: ~~*(5-1-10)*~~( )

01. ~~*Basic and Intensive*~~ Case Management Services. ~~*(5-1-10)*~~( )

a. Services must include a case management assessment of the client and client family strength and needs, service planning, linkage to other services, client advocacy and monitoring ~~*service provisions*~~. ~~*(5-1-10)*~~( )

b. ~~*There must be*~~ The provider must have policies and procedures for ensuring that multiple services are delivered in a coordinated and therapeutic manner to meet the goals of treatment outcomes. ~~*(5-1-10)*~~( )

c. Case management services must not duplicate ~~*case management*~~ services currently provided under any other state-funded program. ~~*(5-1-10)*~~( )

02. Comprehensive Case Management Service Plan Development. The case manager must prepare for each client a comprehensive service plan that addresses the service needs of the client as identified in the current assessment. To the maximum extent possible, the development of the comprehensive service plan must be a collaborative process involving the client~~*, family members,*~~ and other support and service systems. A written comprehensive service plan must be developed in accordance with Section 380 of these rules and implemented within thirty (30) days ~~*after the date the agency first sees the client*~~ of the completion of a case management assessment. The comprehensive service plan must be updated at least every ninety (90) days. Section~~*s*~~ 370 ~~*and 380*~~ of these rules does not apply in this setting. ~~*The individual's comprehensive service plan is based on the Department's Minimum Case Management Standards referenced under Section 002 of these rules.*~~ ~~*(5-1-10)*~~( )

03. Case Manager Contact and Availability. At least every thirty (30) days, case managers must have face-to-face contact with the client, or have contact with the guardian, who can verify the client's well-being and whether services are being provided according to the written plan. The frequency, mode of contact, and person being contacted must be identified in the plan and must meet the needs of the client. ~~*(5-1-10)*~~( )

~~***a.*** *Basic Case Management. The case manager must have a face-to-face contact with each client, at least every month. Contact may be made more often depending upon the level of case management.* *(5-1-10)*~~

~~***b.*** *Intensive Case Management. At least every thirty (30) days, depending upon the level of case management provided, case managers must have additional contact with the client, guardian, or provider who can verify the client's well being and whether services are being provided according to the written plan. The frequency, mode of contact, and person being contacted must be identified in the plan and must meet the needs of the client.* *(5-1-10)*~~

04. Case Manager Qualifications. ~~*A case manager must have completed training in the essentials of case management as identified by the Department. A case manager providing basic or intensive case management must:* (5-1-10)~~( )

a. Be a qualified substance use disorders professional as defined in Section 013 of these rules, an ISAS as defined in Section 012 of these rules, or a qualified substance use disorders professional trainee as defined in Section 013 of these rules. An ISAS or qualified substance use disorders professional trainee may provide case management services only under direct ~~*intensive*~~ clinical supervision and a ~~*learning*~~ professional development plan~~.~~; *or* ~~(5-1-10)~~( )

b. Have a bachelor's degree in a human services field from a nationally-accredited university or college ~~*and at least six (6) months, or one thousand forty (1,040) hours, of supervised experience working with the substance use disorders population; and*~~. ~~*(5-1-10)*~~( )

~~***c.*** *Have a case management certificate issued by the Department after training is completed within six (6) months of hire.* *(5-1-10)*~~

~~***05. Case Manager Status Granted Prior to May 1, 2010****. Subsections 218.01 and 218.02 of these rules are applicable to all new applications for appointment as a case manager submitted to the Department after May 1, 2010. If an individual was granted an appointment prior to May 1, 2010, and met the requirements at that time, he may continue to have his appointment recognized. The appointment of this status will be given by the Department after the Department has received documentation affirming the qualified substance use disorder professional's education and experience meets standards in place prior to May 1, 2010.* *(5-1-10)*~~

0~~6~~5. Staffing. A case manager's total caseload must not be so large that it cannot assure quality service delivery and client satisfaction. (5-1-10)

0~~7~~6. Supervision. The case management program must provide and document at least one (1) hour of case management supervision per month for each case manager. (5-1-10)

a. Case management supervisors must: (5-1-10)

i. Be a qualified substance use disorders professional with a Master's degree in a human services field; or (5-1-10)

ii. Have a Master's degree in a human services field and ~~*one (1) year treatment experience with at least six (6) months, or*~~ one thousand forty (1,040) hours ~~*being*~~ supervised ~~*while*~~ work~~*ing*~~ experience with the substance use disorders population. ~~*(5-1-10)*~~( )

b. Case management supervision must be documented and include the following: the date supervision is provided, the times the supervision begins and ends, the topics discussed, the duration of each session, whether the supervision was to an individual or group, and the signatures and credentials of both the individual conducting the supervision and the individual(s) receiving supervision. (5-1-10)

~~***08. Client Records For Case Management Program****. Department-approved case*~~

~~*management forms must be used and can be found on the Department's website as described in Sections 002 and 005 of these rules. The case management program must maintain a written client record and documentation of services on each client utilizing the forms and procedures described in the Minimum Case Management Standards referenced in Section 002 of these rules. All entries in the client record must be signed and dated. Symbols and abbreviations may be used only if they have been approved by professional staff and only when there is an explanatory legend. Sections 375 and 386 of these rules do not apply in this setting.* (5-1-10)~~

IDAPA 22 - BOARD OF MEDICINE

22.01.01 - RULES OF THE BOARD OF MEDICINE FOR THE LICENSURE TO PRACTICE MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY IN IDAHO

DOCKET NO. 22-0101- 1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1806 (2) and (11), 54-1806A, 54-1812, 54-1813 (2) and 54-1814 and 54-1841, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The reasons for adopting this pending rule are to update the Board's web address, clarify the section relating to Physician Panelist for Prelitigation Consideration of Medical Malpractice Claims and comply with the recommendations of the FBI and local law enforcement pursuant to a review of the Board's fingerprint reporting security procedures. There is no change between the text of the proposed rule and the text of the pending rule. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 483 through 487**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

DATED this 30th day of November, 2012.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720 Boise, ID 83720-0058
Phone: (208) 327-7000 Fax: (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-1806(2), 54-1806(4), (11), 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, Idaho Code.

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

Tuesday - October 23, 2012 - 1:00 to 2:00 p.m.
Idaho State Board of Medicine **Conference Room** **1755 Westgate Drive, Suite 140, Boise, ID**

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

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

The substance and purpose of this rule change is to update the Board's web address, clarify the section relating to Physician Panelist for Prelitigation Consideration of Medical Malpractice Claims and comply with the recommendations of the FBI and local law enforcement pursuant to a review of the Board's fingerprint reporting security procedures.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There will be no increase in fees.

Authority for imposition of fees is found in Sections 54-1806 and 54-1806A (4), Idaho Code.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Board received input and comments from its constituents and licensees.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into

this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 October 24, 2012.

DATED this 21st of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0101-1201

006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.
The central office of the Board of Medicine will be in Boise, Idaho. The Board's mailing address, unless otherwise indicated, will be Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058. The Board's street address is 1755 Westgate Drive, Suite 140, Boise, Idaho 83704. The telephone number of the Board is (208) 327-7000. The Board's facsimile (FAX) number is (208) 327-7005. The Board's web site is www.bom.~~*state id.us*~~idaho.gov. The Board's office hours for filing documents are 8 a.m. to 5 p.m. MST. ~~*(3-30-06)*~~( )

007. FILING OF DOCUMENTS - NUMBER OF COPIES.
All original documents and one (1) electronic copy in rulemaking or contested case proceedings must be filed with the office of the Board. ~~*(3-29-10)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

050. GENERAL QUALIFICATIONS FOR LICENSURE AND RENEWAL.

01. Residence. No period of residence in Idaho shall be required of any applicant, however, each applicant for licensure must be legally able to work and live in the United States. Original documentation of lawful presence in the United States must be provided upon request only. The Board shall refuse licensure or renew a license if the applicant is not lawfully present in the United States. (3-26-08)

02. Character. The Board may refuse licensure if it finds that the applicant has engaged in conduct prohibited by Section 54-1814, Idaho Code; provided the Board shall take into consideration the rehabilitation of the applicant and other mitigating circumstances. (7-1-93)

03. English Language. Each applicant shall speak, write, read, understand and be understood in the English language. Evidence of proficiency in the English language must be provided upon request only. (3-26-08)

04. Application. Each applicant must have graduated from an acceptable school of medicine, passed an examination acceptable to the Board that demonstrates qualification for licensure or successfully completed the United States Medical Licensing Exam (USMLE) and completed one (1) year of postgraduate training approved by the ACGME, AOA or Royal College of Physicians and Surgeons of Canada, and shall submit a completed written application to the Board on forms prescribed by the Board with the nonrefundable application fee. Any certificate or document required to be submitted to the Board which is not in the English language must be accompanied by a certified translation thereof into English. The application form shall be verified and shall require the following: (5-8-09)

a. Personal identification information and education background of the applicant including, but limited to, his college education, medical school education and postgraduate training; (3-26-08)

b. An original certificate or document of graduation from an acceptable school of medicine, and evidence of satisfactory completion of postgraduate training of one (1) year at one (1) training program accredited for internship, residency or fellowship training by the ACGME, AOA or Royal College of Physicians and Surgeons of Canada; (3-26-08)

c. The disclosure of any criminal charges, convictions or guilty pleas against the applicant other than minor traffic offenses; (7-1-93)

d. The current mental and physical condition of the applicant, together with disclosure of any previous physical or mental illness which impacts the applicant's ability to practice medicine; (3-30-01)

e. The disclosure of any past or pending medical malpractice actions against the applicant, and the judgments or settlements, if any, of such claims exceeding fifty thousand dollars ($50,000); (5-8-09)

f. The disclosure of any disciplinary action by any board of medicine, licensing authority, medical society, professional society, hospital, medical school, or institution staff in any state or country; (3-26-08)

g. The disclosure of the refusal to issue or renew a license to practice medicine by any state, Canadian or international licensing authority; (3-26-08)

h. References to include two (2) letters of recommendation signed by licensed physicians who have known the applicant professionally for at least one (1) year; (3-30-06)

i. An unmounted photograph of the applicant, of adequate size and clarity to identify the applicant and no larger than four inches tall by three inches wide (4" x 3"), taken not more than one (1) year prior to the date of the application; (3-30-06)

j. A certified copy of a full set of the applicant's fingerprints on forms supplied by the Board which shall be forwarded to the Idaho Department of Law Enforcement and to the FBI Identification Division for the purpose of a fingerprint-based criminal history check of the Idaho central criminal database and the Federal Bureau of Investigation criminal history database; (5-3-03)

k. The employment history and relevant practice locations of the applicant; (3-30-06)

l. Each state, country and jurisdiction in which the applicant has applied for a license to practice medicine; (3-26-08)

m. Each state, country and jurisdiction wherein the applicant is licensed to practice medicine; ~~*and*~~ ~~*(3-26-08)*~~( )

n. ~~*Such other information or examinations as the Board deems necessary to identify and evaluate the applicant's credentials and competency.*~~ A copy of the applicant's birth certificate or current passport; and ~~*(3-30-06)*~~( )

o. Such other information or examinations as the Board deems necessary to identify and evaluate the applicant's credentials and competency. ( )

05. Examination. Each applicant must pass an examination acceptable to the Board, within the time period recommended by the examination authority, which shall thoroughly test the applicant's fitness to practice medicine or successfully completed the United States Medical Licensing Exam (USMLE). If an applicant fails to pass the examination on two (2) separate occasions the applicant may be required to be interviewed, evaluated or examined by the Board. (5-8-09)

06. Interview. Each applicant may be personally interviewed by the Board or a designated committee of the Board. The interview shall include a review of the applicant's qualifications and professional credentials. (3-30-01)

07. Applicants. All applicants must complete their license application within one (1) year unless extended by the Board after filing an application for extension. Unless extended, applications that remain on file for more than one (1) year will be considered null and void and a new application and new fees will be required as if filing for the first time. (3-30-06)

08. Health Care Standards. In reviewing the application or conducting the applicant's interview, the Board shall determine whether the applicant possesses the requisite qualifications to provide the same standard of health care as provided by licensed physicians in this state. If the Board is unable to reach such a conclusion through the application and interview, it shall conduct further inquiry, to establish such qualifications. (3-30-06)

a. Upon inquiry, if further examination is required, the Board may require passage of the Special Purpose Examination (SPEX) administered by the FSMB, a post licensure assessment conducted by the FSMB, or an evaluation by an independent agency accepted by the Board to evaluate physician competence. (5-8-09)

b. The Board will require further inquiry when in its judgment the need is apparent, including but not limited to the following circumstances: (3-30-06)

i. Graduate of an international medical school located outside the United States and Canada and not accredited by the LCME; (5-8-09)

ii. Applicant whose background investigation reveals evidence of impairment, competency deficit, or disciplinary action by any licensing or regulatory agency; (3-26-08)

iii. An applicant has not been in active medical practice for a period exceeding one (1) year, or when practice has been significantly interrupted; (3-30-06)

iv. An applicant has not written a recognized examination intended to determine ability to practice medicine within a period of five (5) years preceding application; (3-30-06)

v. An applicant whose initial licensure was issued on the basis of an examination not recognized by the Board; or (3-30-06)

vi. When there is any reason whatsoever to question the identity of the applicant. (3-30-06)

c. Recommendations of the assessment and or evaluation acceptable to the Board related to the ability of the applicant to practice medicine and surgery will be considered by the Board in its decision whether to issue a license and the Board may limit, condition, or restrict a license based on the Board's determination and the recommendation of the assessment or evaluation. (3-30-06)

(BREAK IN CONTINUITY OF SECTIONS)

081. PHYSICIAN PANELIST FOR PRELITIGATION CONSIDERATION OF MEDICAL MALPRACTICE CLAIMS.

01. Purpose. The purpose of serving as a physician panelist for prelitigation consideration of medical malpractice claims against physicians and surgeons practicing in the state of Idaho or against licensed acute care general hospitals operating in the state of Idaho is to: ( )

a. ~~c~~Cooperate in the prelitigation consideration of personal injury and wrongful death claims for damages arising out of the provision of or alleged failure to provide hospital or medical care in Idaho; and ( )

b. ~~to a~~Accept and hear complaints of such negligence and damages, made by or on behalf of any patient who is an alleged victim of such negligence. ~~(5-8-09)~~( )

02. Eligibility. A physician licensed to practice medicine and surgery or osteopathic

medicine or surgery in Idaho shall be available to serve in any two (2) year period, or a longer period not to exceed five (5) years, as determined by the panel chairman, as a physician panelist for prelitigation consideration of a medical malpractice claim. (5-8-09)

03. Excusing Physicians from Serving. A physician panelist so selected shall serve unless he had served on a prelitigation panel during any previous two (2) year period, or a longer period not to exceed five (5) years, as determined by the panel chairman or for good cause shown, is excused by the panel chairman. To show good cause for relief from serving, the selected physician panelist shall present an affidavit to the panel chairman which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The panel chairman shall have the sole authority to excuse a selected physician from serving on a prelitigation panel. (5-8-09)

04. Penalties for Noncompliance. The Board may condition, limit, suspend, or refuse to renew the license of any physician whom the Board determines has failed to serve as a physician panelist for the prelitigation consideration of a medical malpractice claim. (5-8-09)

IDAPA 22 - BOARD OF MEDICINE

22.01.11 - RULES FOR LICENSURE OF RESPIRATORY THERAPISTS AND PERMITTING OF POLYSOMNOGRAPHERS IN IDAHO

DOCKET NO. 22-0111-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-4304A, 54-4305, 54-4309, 54-4310, 54-4311, 54-4312 and 54-4316, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule:

The reasons for adopting this pending rule are to enhance the guidance of polysomnographic trainees via direct on-site supervision, prohibit polysomnographic technicians from applying for temporary permits as polysomnographic trainees and requiring an original and one (1) electric copy of all documents in contested case proceedings. There is no change between the text of the proposed rule and the text of the pending rule. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 496 through 504**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

DATED this 30th day of November, 2012.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720 Boise, ID 83720-0058
Phone: (208) 327-7000 Fax: (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 54-4304A, 54-4305, 54-4309, 54-4310, 54-4311, 54-4312 and 54-4316, Idaho Code.

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

Tuesday - October 23, 2012 - 1:00 to 2:00 p.m.
Idaho State Board of Medicine **Conference Room** **1755 Westgate Drive, Suite 140, Boise, ID**

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

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

The substance and purpose of this rule change is to enhance the guidance of polysomnographic trainees via direct on-site supervision, prohibit polysomnographic technicians from applying for temporary permits as polysomnographic trainees and requiring an original and one (1) electronic copy of all documents in contested case proceedings.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There will be no increase in fees. Authority for imposition of fees is found in Sections 54-1806 and 54-1806A (4), Idaho Code.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Board received input and comments from its constituents and licensees.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 October 24, 2012.

DATED this 21st of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0111-1201

006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.
The central office of the Board of Medicine will be in Boise, Idaho. The Board's mailing address, unless otherwise indicated, will be Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058. The Board's street address is 1755 Westgate Drive, Suite 140, Boise, Idaho 83704. The telephone number of the Board is (208) 327-7000. The Board's facsimile (FAX) number is (208) 327-7005. The Board's web site is www.bom.~~*state id.us*~~idaho.gov. The Board's office hours for filing documents are 8 a.m. to 5 p.m. MST. ~~*(3-30-06)*~~( )

007. FILING OF DOCUMENTS -- NUMBER OF COPIES.
All documents in rulemaking or contested case proceedings must be filed with the office of the Board. The original and ~~*ten*~~ one (1~~0~~) electronic cop~~*ies*~~y of all documents must be filed with the office of the Board. ~~*(3-16-04)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Act. The Respiratory Care Practice Act of 1991, Title 54, Chapter 43, Idaho Code. (4-28-93)

02. Applicant. A person who applies for a license, dual license/permit, permit, conditional permit, or a temporary permit pursuant to this chapter and Title 54, Chapter 43, Idaho Code. (3-16-04)

03. Board. The Idaho State Board of Medicine, established pursuant to Section 54-1805, Idaho Code. (3-16-04)

04. Board of Registered Polysomnographic Technologists. A nationally recognized

private testing, examining and credentialing body for the polysomnography related respiratory care profession. (3-16-04)

05. Certified Pulmonary Function Technologist (CPFT). The professional designation earned by a person who has successfully completed the entry level pulmonary function certification examination administered by the National Board for Respiratory Care, Inc., or by an equivalent board, recognized by the Board. (3-16-04)

06. Certified Respiratory Therapist (CRT). The professional designation earned by a person who has successfully completed the entry level examination administered by the National Board for Respiratory Care, Inc., or by an equivalent board, recognized by the Board. (3-16-04)

07. Comprehensive Registry Exam. The comprehensive registry examination administered by the Board of Registered Polysomnographic Technologists, or administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person to the professional designation of Registered Polysomnographic Technologist (RPSGT). (3-16-04)

08. Conditional Permit. A time-restricted permit issued by the Board, upon the recommendation of the Licensure Board, as set forth in this chapter and Section 54-4304A, Idaho Code, to a registered polysomnographic technologist, polysomnographic technician or a polysomnographic trainee, on or after January 1, 2004, and issued until issuance of permits as provided in this chapter. (3-16-04)

09. Entry Level Examination. The certification examination for entry level respiratory therapy practitioners administered by the National Board for Respiratory Care, Inc., or certification examination administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person to the professional designation of "Certified Respiratory Therapist" (CRT). (3-16-04)

10. Licensed Physician. A physician licensed to practice medicine and surgery or osteopathic medicine and surgery, by the Idaho State Board of Medicine. (3-16-04)

11. Licensure. The issuance of a license to an applicant under the provisions of this chapter and Title 54, Chapter 43, Idaho Code entitling such person to hold himself out as a respiratory care practitioner and to practice or perform respiratory care in this state. (3-16-04)

12. Licensure Board. The Licensure Board established by this chapter and Section 54-4313, Idaho Code. (3-16-04)

13. Medical Practice Act. The Medical Practice Act of 1977, Title 54, Chapter 18, Idaho Code. (3-26-08)

14. National Board of Respiratory Care, Inc. A nationally recognized private testing, examining and credentialing body for the respiratory care profession. (3-16-04)

15. Performance of Respiratory Care. Respiratory care practiced or performed in

accordance with the written, telephonic or verbal prescription of a licensed physician and includes, but is not limited to, the diagnostic and therapeutic use of the following: administration of medical gases, (except for the purpose of anesthesia), aerosols and humidification; environmental control mechanisms and hyperbaric therapy, pharmacologic agents related to respiratory care protocols, mechanical or physiological ventilatory support; bronchopulmonary hygiene, cardiopulmonary resuscitation; maintenance of the natural airway; insertion and maintenance of artificial airways; specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment and research of pulmonary abnormalities, including measurements of ventilatory volumes, pressures and flows, collection, reporting and analysis of specimens of blood and blood gases, arterial punctures, insertion and maintenance of arterial lines, expired and inspired gas samples, respiratory secretions, and pulmonary function testing; and hemodynamic and other related physiologic measurements of the cardiopulmonary system, observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and determination of whether such signs, symptoms, reactions, behavior or general response exhibit abnormal characteristics; implementation based on observed abnormalities of appropriate reporting or referral of respiratory care or changes in treatment regimen, pursuant to a prescription by a physician or the initiation of emergency procedures. (4-28-93)

16. Permit. The issuance of a permit to an applicant under the provisions of this chapter and Section 54-4304A, Idaho Code, entitles such person to hold himself out as a registered polysomnographic technologist, polysomnographic technician, or polysomnographic trainee and to perform polysomnography related respiratory care in this state. (3-16-04)

17. Person. A natural living human individual. (3-16-04)

18. Polysomnographic Technician. A person who holds a permit as set forth in this chapter and Section 54-4304A, Idaho Code, and who performs polysomnography related respiratory care services under the supervision of an Idaho permitted registered polysomnographic technologist, licensed respiratory care practitioner or an Idaho licensed physician. (3-16-04)

19. Polysomnographic Trainee. A person who holds a temporary permit as set forth in this chapter and Section 54-4304A, Idaho Code, and who performs polysomnography related respiratory care services under the direct supervision of an Idaho licensed respiratory care practitioner, or a person exempt from such licensure pursuant to this chapter and Section 54-4308, Idaho Code, an Idaho permitted registered polysomnographic technologist, an Idaho permitted polysomnographic technician or an Idaho licensed physician. Direct supervision by an Idaho licensed respiratory care practitioner, or such person exempt from such licensure pursuant to this chapter and Section 54-4308, Idaho Code, or an Idaho permitted registered polysomnographic technologist or technician, or an Idaho licensed physician, means that such a person shall be on the ~~*premises*~~ same site where such polysomnographic related respiratory care services are provided and shall be immediately available for consultation with the polysomnographic trainee. ~~*(3-16-04)*~~( )

20. Polysomnography. The process of analysis, attended monitoring and recording of physiologic data during sleep and wakefulness to assist in the assessment and diagnosis of sleep/

wake disorders and other disorders, syndromes and dysfunctions that either are sleep related, manifest during sleep or disrupt normal sleep/wake cycles and activities. (3-16-04)

21. Polysomnography Related Respiratory Care Services. The limited practice of respiratory care in the provision of polysomnography services, under the supervision of an Idaho licensed physician, by a person at a sleep disorder center or laboratory who holds a permit issued by the Board, as a registered polysomnographic technologist, polysomnographic technician or a polysomnographic trainee, or who is otherwise licensed as a respiratory care practitioner or who is exempt from licensure or permitting pursuant to this chapter and Section 54-4308, Idaho Code. Polysomnography related respiratory care services include therapeutic and diagnostic use of oxygen, noninvasive ventilatory assistance of spontaneously breathing patients and cardiopulmonary resuscitation and maintenance of nasal and oral airways that do not extend into the trachea, as ordered by an Idaho licensed physician or by written procedures and protocols of the associated sleep disorder center or laboratory as approved by an Idaho licensed physician and which do not violate any rules adopted by the Board. This chapter does not in any way authorize the practice of medicine or any of its branches by any person not so licensed by the Board. Further, licensed respiratory practitioners, and those exempt from licensure pursuant to this chapter and Section 54-4308, Idaho Code, are not limited in their scope of practice of provision of respiratory care, which they may provide, including care in connection with the provision of polysomnography services. (3-16-04)

22. Practice of Respiratory Care. Means, but shall not be limited to, the provision of respiratory and inhalation therapy which shall include, but not be limited to: therapeutic and diagnostic use of medical gases, humidity and aerosols including the maintenance of associated apparatus; administration of drugs and medications to the cardiorespiratory system; provision of ventilatory assistance and ventilatory control; postural drainage, percussion, breathing exercises and other respiratory rehabilitation procedures; cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways; and the transcription and implementation of a physician's written, telephonic or verbal orders pertaining to the practice of respiratory care. It also includes testing techniques employed in respiratory care to assist in diagnosis, monitoring, treatment and research. This shall be understood to include, but not be limited to, measurement of ventilatory volumes, pressures and flows, specimen collection of blood and other materials, pulmonary function testing and hemodynamic and other related physiological monitoring of the cardiopulmonary system. The practice of respiratory care is not limited to the hospital setting but shall be performed under the general supervision of a licensed physician. (4-28-93)

23. Respiratory Care Protocols. Policies, procedures or protocols developed or instituted by health care facilities or institutions, through collaboration when appropriate or necessary with administrators, physicians, registered nurses, physical therapists, respiratory care practitioners and other licensed, certified or registered health care practitioners. (4-28-93)

24. Registered Polysomnographic Technologist (RPSGT). The professional designation earned by a person who has successfully completed the comprehensive registry examination administered by the Board of Registered Polysomnographic Technologists, or by an equivalent board, recognized by the Board, and who holds a permit as set forth in this chapter and Section 54-4304A, Idaho Code, and who works under the supervision of an Idaho licensed physician to provide polysomnography related respiratory care services. (3-16-04)

25. Registered Pulmonary Function Technologist (RPFT). The professional designation earned by a person who has successfully completed the advanced pulmonary function certification examination administered by the National Board for Respiratory Care, Inc., or an advanced pulmonary function certification examination administered by an equivalent board, recognized by the Board. (3-16-04)

26. Registered Respiratory Therapist (RRT). The professional designation earned by a person who has successfully completed the written registry and clinical simulation examinations administered by the National Board for Respiratory Care, Inc., or certification examinations administered by an equivalent board, recognized by the Board. (3-16-04)

27. Respiratory Care. Allied health profession responsible for the treatment, management, diagnostic testing, control and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system, under the general supervision of a licensed physician. (2-23-94)

28. Respiratory Care Practitioner. A person who has been issued a license by the Board. (3-16-04)

29. Respiratory Therapist. A person who practices or provides respiratory care. (4-28-93)

30. Respiratory Therapy. The practice or performance of respiratory care, including but not limited to, inhalation therapy. (4-28-93)

31. Sleep Disorder Center or Laboratory. A facility for sleep related disorders that provides polysomnography and is under the supervision of an Idaho licensed physician or medical director licensed by the Board who is responsible for patient care provided in such center or laboratory. A sleep disorder center or laboratory that provides polysomnography related respiratory care to patients shall have an Idaho licensed respiratory care practitioner, an Idaho permitted registered polysomnographic technologist, an Idaho permitted polysomnographic technician, or a person exempt from licensure or permitting pursuant to this chapter and Section 54-4308, Idaho Code, in constant attendance. (3-16-04)

32. Supervision of Respiratory Care. The practice or provision of respiratory care by persons holding a student or consulting and training exemption, or temporary permit shall be in direct association with a respiratory care practitioner or licensed physician who shall be responsible for the activities of the person being supervised and shall review and countersign all patient documentation performed by the person being supervised. The supervising respiratory care practitioner or licensed physician need not be physically present or on the premises at all times but must be available for telephonic consultation. The extent of communication between the supervising or consulting respiratory care practitioner or licensed physician and the person being supervised shall be determined by the competency of the person, the treatment setting, and the diagnostic category of the client. (3-26-08)

33. Temporary Permit. The Board may issue a temporary permit, limited to a total period of two (2) years, including initial and renewal, to a respiratory care practitioner applicant

who meets the requirements set forth in this chapter and Section 54-4307, Idaho Code. The Board may issue a temporary permit, limited to a total period of two (2) years, including initial and renewal, to a polysomnographic trainee applicant who meets the requirements set forth in this chapter and Section 54-4304A, Idaho Code. (3-16-04)

34. Written Registry and Clinical Simulation Examinations. The certification examinations administered by the National Board of Respiratory Care, Inc., or certification examinations administered by an equivalent board, recognized by the Board, the successful completion of which entitles a person the professional designation of "Registered Respiratory Therapist" (RRT). (3-16-04)

(BREAK IN CONTINUITY OF SECTIONS)

032. APPLICATION FOR LICENSURE AND PERMITS.

01. All Applications. Each applicant for licensure or permit shall submit a completed written application to the Board on forms prescribed by the Board, together with the application fee. The Board may, in its discretion, prorate the application fees charged in conjunction with an application for initial licensure or a temporary permit if such license or temporary permit shall, upon issuance, remain valid for less than one (1) full calendar year before the required renewal date as provided for in Sections 54-4309 and 54-4310, Idaho Code. The application shall be verified and under oath and shall require documentation of the following information: (4-11-06)

a. The disclosure of any criminal conviction or charges against the applicant other than minor traffic offenses, what ever the outcome; and ~~(2-23-94)~~( )

b. The disclosure of any charge, investigation or disciplinary action against the applicant by any state professional regulatory agency or professional organization that bears a demonstrable relationship to the ability of the applicant to practice in accordance with the provisions of this chapter; and (3-16-04)

c. The disclosure of the denial of registration or licensure by any country, state or district regulatory body; and (3-26-08)

d. Not less than two (2) certificates of recommendation from persons, other than relatives or persons living with the applicant, who have personal knowledge of at least one (1) year of the applicant's character and the applicant's ability to work as a respiratory therapist or provide polysomnography related respiratory care services; and (3-26-08)

e. One (1) unmounted photograph of the applicant, no larger than three by four inch (3" x 4") (head and shoulders), taken not more than one (1) year prior to the date of the application; and (2-23-94)

f. Such other information as deemed reasonably necessary and as is lawful for the Board to identify and evaluate the applicant's credentials; and (3-16-04)

g. Evidence that applicant is no less than eighteen (18) years of age. (3-16-04)

h. The Board may, at its discretion, require the applicant to appear for a personal interview. (3-16-04)

02. Application for Respiratory Care Practitioner. (3-16-04)

a. Documentation of evidence that applicant has passed the entry level examination and is a Certified Respiratory Therapist (CRT) or has successfully completed the written registry and clinical simulation examinations and is a Registered Respiratory Therapist (RRT); or (3-16-04)

b. Documentation that the applicant is licensed as a respiratory care practitioner, or the equivalent at the discretion of the Board, in another state, district or territory of the United States. (3-16-04)

c. Application for Temporary Permit. The Board may issue a temporary permit to an applicant who meets the requirements set forth in this chapter and Section 54-4307, Idaho Code. A temporary permit shall authorize the practice of respiratory care under the supervision of a respiratory care practitioner or licensed physician. (3-16-04)

i. A temporary permit for a respiratory care practitioner may be converted to a permanent license by providing to the Board, verification of appropriate certification as a Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT). (3-16-04)

ii. A temporary permit shall be effective for one (1) year from the date of issuance. (4-28-93)

iii. A temporary permit may be renewed one (1) time only for a period of one (1) year, upon application to the Board. ~~*(4-28-93)*~~( )

iv. Application for a temporary permit shall be made to the Board on a form prescribed by the Board, together with the application fee. The Board may, in its discretion, prorate the application fees charged in conjunction with an initial application for a temporary permit if such temporary permit shall, upon issuance, remain valid for less than one (1) full calendar year before the required renewal date as provided for in Sections 54-4309 and 54-4310, Idaho Code. (4-11-06)

03. Application for Inactive License. A person holding a current license issued by the Board to practice as a respiratory care practitioner may be issued, upon written application provided by the Board and payment of required fees to the Board, an inactive license on the condition that he will not engage in the provision of respiratory care services as a respiratory care practitioner in this state. (3-16-04)

a. Issuance and Renewal. Inactive licenses shall be issued for a period of not more than five (5) years and such licenses shall be renewed upon payment of an inactive license renewal fee of no more than one hundred dollars ($100) for each renewal year. Such inactive

licenses shall expire on the expiration date printed on the face of the certificate unless renewed. (3-26-08)

b. Inactive to Active License. An inactive license may be converted to an active license to practice as a respiratory care practitioner upon written application and payment of active licensure fees for each inactive year minus paid inactive fees plus a conversion fee of no more than one hundred dollars ($100) to the Board. The applicant must account for the time during which an inactive license was held and document continuing competence. The Board may, in its discretion, require a personal interview to evaluate the applicant's qualifications. In addition, the Board may require evidence of an educational update and close supervision to assure safe and qualified performance. (3-26-08)

04. Application for Respiratory Care and Polysomnography Related Respiratory Care Practitioner. (3-16-04)

a. The Board may issue a dual license/permit to an applicant who meets the requirements set forth in this chapter and Sections 54-4306 and 54-4304A(2) and (3), Idaho Code. A dual license/permit shall authorize the holder to perform respiratory care and polysomnography related respiratory care in this state. (3-16-04)

b. Application for a dual license/permit shall be made to the Board on a form prescribed by the Board, together with the application fee. (3-16-04)

c. Such dual license/permit shall expire on the expiration date printed on the face of the certificate unless renewed. (3-16-04)

05. Application for Polysomnography Related Respiratory Care Practitioner. (3-16-04)

a. Only persons who are licensed as respiratory care practitioners or who are exempt from licensure pursuant to the chapter and Section 54-4308, Idaho Code, or who hold a permit issued by the Board as registered polysomnographic technologists, polysomnographic technicians or polysomnographic trainees may provide polysomnography related respiratory care services. (3-16-04)

b. Qualifications for permit. An applicant for a permit to provide polysomnography related respiratory care services as a registered polysomnographic technologist or polysomnographic technician or for a temporary permit as a polysomnographic trainee under the provisions of Section 032 who is not otherwise licensed to provide respiratory care services or exempt from the requirements of this chapter pursuant to Section 54-4308, Idaho Code, must provide documentation of: (3-16-04)

i. Being a high school graduate or have passed a general educational development (GED) examination and earned a GED certificate; and (3-16-04)

ii. Being currently certified in cardiopulmonary resuscitation (CPR). (3-16-04)

c. Application for Registered Polysomnographic Technologist. An applicant must

provide documentation of successful completion of the comprehensive registry examination as a registered polysomnographic technologist administered by the Board of Registered Polysomnographic Technologists or an equivalent examination, approved by the Board as recommended by the Licensure Board. (3-16-04)

d. Application for Polysomnographic Technician. An applicant must provide written documentation and a signed affidavit affirming and attesting to one (1) of the following qualifications: (3-16-04)

i. Successful completion of a polysomnography program of not less than one (1) year duration, associated with a state licensed or a nationally accredited educational facility, as approved by the Board, as recommended by the Licensure Board; or (3-16-04)

ii. Successful completion of a minimum of seven hundred twenty (720) hours of experience as a polysomnographic trainee with documented proficiency in polysomnography related respiratory care services, as approved by the Board, as recommended by the Licensure Board. (3-16-04)

e. Application for Polysomnographic Trainee. An applicant must provide a signed affidavit from an Idaho permitted registered polysomnographic technologist, an Idaho permitted polysomnographic technician, an Idaho licensed respiratory care practitioner, or an Idaho licensed physician affirming and attesting he shall ensure that there is direct supervision of performance of basic polysomnography related respiratory care services by a polysomnographic trainee applicant. The direct supervisor shall be on the premises where such polysomnographic related respiratory care services are provided and shall be immediately available for consultation with the polysomnographic trainee applicant. The Affiant need not be the direct supervisor at any given time. Such Affiant shall be responsible for the activities of the supervised polysomnographic trainee and shall document his review of all patient documentation performed by the supervised polysomnographic trainee. If at any time during the term of the polysomnographic trainee's permit, the Affiant of the trainee changes, the polysomnographic trainee shall provide a signed affidavit from his new Affiant who will ensure that the trainee has direct supervision. In addition, the applicant shall provide written documentation he has at least one (1) of the following qualifications: (3-16-04)

i. At least seven hundred twenty (720) hours of experience as a paid employee or contractor in a health care related field. For the purposes of this Section, experience as a paid employee or contractor in a health care related field shall include any work providing direct clinical care to patients or having worked in a clinical care setting in which the applicant had direct interaction with patients, and an opportunity to observe the provision of clinical care to patients; (3-16-04)

ii. Current enrollment in a polysomnography program associated with a state licensed or a nationally accredited education facility; or (3-16-04)

iii. Successful completion of twenty-four (24) semester credit hours (or a quarter (¼) hour system equivalent of the same) of postsecondary education at a state licensed or nationally accredited facility. (3-16-04)

f. Permits. All permits shall be issued after applicants have met the requirements of this chapter and Section 54-4304A, Idaho Code and submitted a completed application and payment of a fee in an amount to be fixed by the Board for a period of not less than one (1) year nor more than five (5) years, the exact period to be fixed by the Board. Such permits shall expire on the expiration date printed on the face of the certificate unless renewed. The failure of any person to renew a renewable permit shall not deprive such person of the right to renewal, except as provided for herein and Section 54-4312, Idaho Code. The Board shall collect a fee in an amount to be fixed by the Board for the initial issuance and each renewal year. (3-16-04)

i. Permits for registered polysomnographic technologists, including renewals, shall be issued for a period of not less than one (1) year nor more than five (5) years. Such permits shall be renewed on their expiration date upon completion of a renewal application and upon payment of a renewal fee. (3-16-04)

ii. Permits for polysomnographic technicians, including renewals, shall be issued for a period of one (1) year, and shall be renewed for successive one (1) year periods, not to exceed three (3) renewals for a total period of four (4) years. Such permits shall be renewed on their expiration date upon completion of a renewal application and upon payment of a renewal fee. (3-16-04)

iii. Temporary permits for polysomnographic trainees shall be issued for a period of not more than one (1) year, the exact period to be fixed by the Board. Such permits may be renewed on their expiration date upon completion of a renewal application and upon payment of a renewal fee, for a period of one (1) year, with renewal limited to one (1) such renewal, provided however, such permits for polysomnographic trainees shall be limited to a total period of two (2) years. The Board may, in its discretion, prorate the application fees charged in conjunction with an initial application for a temporary permit if such temporary permit shall, upon issuance, remain valid for less than one (1) full calendar year before the required renewal date as provided for in Sections 54-4309 and 54-4310, Idaho Code. Those who have held permits as a polysomnographic technicians are prohibited from making application for temporary permits as a polysomnographic trainees. ~~*(4-11-06)*~~( )

iv. Reinstatement after failure to renew. Permits canceled for nonpayment of renewal fees may be reinstated by filing a completed request for renewal with the Board and paying a reinstatement fee, and back renewal fees. (3-16-04)

v. Reapplication after failure to renew. A registered polysomnographic technologist, whose permit has been canceled for failure to renew for a period of more than two (2) years, shall be required to make application to the Board as a new applicant for a permit. A polysomnographic technician, whose permit has been canceled for failure to renew for a period of more than one (1) year, shall be required to make application to the Board as a new applicant for a permit. Temporary permits for polysomnographic trainees whose permits have been canceled for failure to renew for a period of more than six (6) months shall be required to make application to the Board as new applicants for permits. (3-16-04)

vi. Continuing education. Each individual applicant for renewal of an active permit shall, on or before the expiration date of the permit, submit satisfactory proof to the Licensure Board of successful completion of not less than twelve (12) hours of approved continuing

education pertaining to the provision of polysomnographic-related respiratory care per year in addition to any other requirements for renewal as adopted by the Board. The Board, as recommended by the Licensure Board, may substitute all or a portion of the coursework required in Section 032 when an applicant for renewal shows evidence of passing an approved challenge exam or of completing equivalent education as determined by the Board, as recommended by the Licensure Board, to be in full compliance with the education requirements of this chapter. (3-16-04)

g. Conditional Permits. Any person who desires to provide polysomnography related respiratory care services as described in Section 54-4304A, Idaho Code, and this chapter and who meets the requirements of Subsection 032.03, as well as the necessary requirements in Subsections 032.05.g.i. through 032.05.g.iv., may make application for a conditional permit. Conditional permits shall be issued on or after January 1, 2004, as outlined in Section 54-4304A(8), Idaho Code, and shall be issued until the Board has adopted rules as may be required for the issuance of regular permits as provided in this chapter and has had an opportunity to process applications for such regular permits. (3-26-08)

IDAPA 22 - BOARD OF MEDICINE

22.01.12 - RULES RELATING TO HEALTH CARE WORKERS

DOCKET NO. 22-0112-1201 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1806A, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule:

The reasons for adopting this pending rule to repeal IDAPA 22.01.12, "Rules Relating to Health Care Workers" are that it is obsolete and redundant. Enacted in 1993, these rules have never been utilized or employed for any health care worker licensed by the Board. Existing rules govern in cases of inability of licensees to practice with reasonable skill or safety. There is no change between the text of the proposed rule and the text of the pending rule.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, page 505**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

DATED this 30th day of November, 2012.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720 Boise, ID 83720-0058
Phone: (208) 327-7000 Fax: (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-1806A, Idaho Code.

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

Tuesday - October 23, 2012 - 1:00 to 2:00 p.m.
Idaho State Board of Medicine **Conference Room** **1755 Westgate Drive, Suite 140, Boise, ID**

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

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

The purpose of this proposed rule change is to repeal IDAPA 22.01.12, "Rules Relating to Health Care Workers." This proposed rule repeal is necessary due to obsolescence and redundancy. Enacted in 1993, these rules have never been utilized or employed for any health care worker licensed by the Board. Existing rules govern in cases of inability of licensees to practice with reasonable skill or safety.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Board also received input and comments from its constituents and licensees.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact

Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 October 24, 2012.

DATED this 21st of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0112-1201

IDAPA 22.01.12 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 22 - BOARD OF MEDICINE

22.01.14 - RULES RELATING TO COMPLAINT INVESTIGATION

DOCKET NO. 22-0114-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to 54-1806(2), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule:

The reasons for adopting this pending rule are to assure Idaho's public health, safety and welfare by updating and clarifying the complaint investigation process which initiates review of a licensee's provision of health care. This rule change will provide explanations and information, elaborating on the format for complaint submission, clarifying the Board's determination of authority and expounding on indications for investigation. There is no change between the text of the proposed rule and the text of the pending rule. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, page 510 through 515**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

DATED this 30th day of November, 2012.

Nancy M. Kerr, Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Ste. 140, Boise, ID
PO Box 83720 Boise, ID 83720-0058
Phone: (208) 327-7000 Fax: (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-1806(2), Idaho Code.

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

Tuesday - October 23, 2012 - 1:00 to 2:00 p.m.
Idaho State Board of Medicine **Conference Room** **1755 Westgate Drive, Suite 140, Boise, ID**

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

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

This rule change is required to assure the public health, safety and welfare in the state of Idaho by updating and clarifying the complaint investigation process. This rule change will provide explanations and information for those wishing to file a complaint against a licensee.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Board also received input and comments from its constituents and licensees.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2) (a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 October 24, 2012.

DATED this 21st of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0114-1201

002. WRITTEN INTERPRETATIONS.
Written interpretations of these rules in the form of explanatory comments accompanying the notice of proposed rule-making that originally proposed the rules and review of comments submitted in the rulemaking process in the adoption of these rules are available for review and copying at cost from the Board ~~*Of Medicine*~~, 1755 Westgate Drive, Suite 140, Box 83720 Boise, Idaho 83720-0058. ~~*(3-30-01)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.
The central office of the Board ~~*of Medicine will*~~ shall be in Boise, Idaho. The Board's mailing address, unless otherwise indicated, ~~*will*~~ shall be Idaho State Board of Medicine, Statehouse Mail, Boise, Idaho 83720. The Board's street address is 1755 Westgate Drive, Suite 140, Boise, Idaho 83704. The telephone number of the Board is (208) 327-7000. The Board's facsimile (FAX) number is (208) 377-7005. The Board's website is www.bom.idaho.gov. The Board's office hours for filing documents are 8:00 a.m. to 5:00 p.m. MST. ~~*(3-30-01)*~~( )

007. FILING OF DOCUMENTS -- NUMBER OF COPIES.
All documents in rulemaking or contested case proceedings must be filed with the office of the Board. The original and ~~*ten*~~ one (1~~0~~) electronic cop~~*ies*~~y of all documents must be filed with the office of the Board. ~~*(3-16-04)*~~( )

008. -- 009. (RESERVED)

010. COMPLAINTS.
All received ~~*C*~~complaints ~~*received*~~, ~~*which are*~~ related to allegations against health care providers regulated by the Board, shall be referred to the appropriate Quality Assurance ~~*staff*~~ Specialist (QAS). ~~*(3-30-01)*~~( )

011. FORMAT FOR SUBMISSION OF COMPLAINT.
Complaints ~~*will*~~ shall be submitted in writing to the Board, ~~*with*~~ and include, but are not limited to, the name of the provider, the approximate date of the incident or care, the ~~*individual's*~~ concerns

regarding the incident or care, and the ~~*name*~~ complainant's signature, telephone number, and address ~~*of the complainant*~~. ~~*(3-15-02)*~~( )

012. DETERMINATION OF AUTHORITY.
After preliminary investigation, ~~*the Quality Assurance Specialist*~~ a ~~(~~QAS~~)~~ shall determine if the complaint falls within the Board's statutory authority ~~*of the Board*~~ as defined in the appropriate practice act and rules. Questions related to jurisdiction ~~*will*~~ shall be referred to the Executive Director and/or Board Counsel. ~~*(3-15-02)*~~( )

01. Outside Statutory Authority. If the complaint falls outside of the Board's statutory authority ~~*of the Board*~~, the QAS shall notify the complainant in writing and may offer referral to an appropriate agency, if indicated. The ~~*staff will*~~ Board shall maintain a copy of the complaint, response, and the preliminary investigation file for a period of one (1) year. Each ~~*file*~~ complaint determined to be outside the Board's statutory authority ~~*of the Board will*~~ shall be reviewed by the Committee on Professional Discipline at its next scheduled meeting. ~~*(3-15-02)*~~( )

02. Within Statutory Authority. If the complaint falls within the Board's authority ~~*of the Board*~~, the QAS ~~*will*~~ shall: ~~*(3-30-01)*~~( )

a. Establish a complaint file; (3-30-01)

b. Assign a case number; (3-30-01)

c. Enter the complaint information ~~*regarding the complaint o*~~into the Board's database. ~~*(3-30-01)*~~( )

d. Correspond in writing ~~*with*~~ to the complainant ~~*and the provider*~~ within ten (10) business days, when possible, ~~*explaining the nature of the complaint*~~ and provide written information regarding the complaint process; ~~*(3-30-01)*~~( )

e. Correspond in writing to the provider within ten (10) business days, when possible, explaining the nature of the complaint and ~~*P*~~provide written information ~~*to the complainant and provider*~~ regarding the complaint process; ~~*(3-30-01)*~~( )

f. Monitor the case to insure the provider has replied and ~~*that*~~ correspond in writing to the complainant and the provider ~~*are kept informed*~~ advising of the case's status ~~*of the investigation*~~ at least every forty-five (45) to sixty (60) days. ~~*(3-30-01)*~~( )

g. The QAS may request any additional information deemed necessary to fully investigate the complaint, including but not limited to: (3-15-02)

i. Interviewing the complainant and the respondent; (3-15-02)

ii. Requesting additional records, documents, or statements; and (3-15-02)

iii. Collecting collateral information. (3-15-02)

013. COMPLAINT AUTHORITY.
At the time the ~~*complaint*~~ case is opened, the ~~*Quality Assurance Specialist will*~~ QAS shall assign a priority rating* (*rating may change at any point in the investigation as new information is received) to the investigation according to the following table:

CATEGORY	DESCRIPTION	EXAMPLE
1	Imminent, or current danger to the public.	Impairment by psychiatric or substance abuse problems.
2	Threat to the public, currently monitored or controlled.	Retired, incarcerated, enrolled in recognized treatment program poses no immediate threat to the public.
3	Identified as having practice, skills, or judgment concern considered a potential threat to the public.	Prescribing concerns, isolated incident of error, negligence, or misconduct.
4	Medium to low risk to public.	Improper delegation Disciplinary action in another state
5	Low risk to public.	Paperwork problems Record keeping issues Failure to transfer medical records.

~~*(3-30-01)*~~( )

01. Category One. Cases assigned as Category one (1) ~~*requires*~~ shall be immediately ~~*referral*~~ reported to the Executive Director for appropriate action. ~~*(3-30-01)*~~( )

02. Category Two. Cases assigned as Category two (2) is shall be reported to the Executive Director for appropriate action. ~~*(3-30-01)*~~( )

014. -- 019. (RESERVED)

020. REPORT OF INVESTIGATION.
~~*When*~~ Upon receipt of the ~~*needed*~~ response and documentation ~~*is received*~~ obtained from the investigation, QAS shall prepare a report containing the following: ~~*(3-30-01)*~~( )

01. Provider Information. The name of the provider, ~~*city*~~ address, specialty, and date of Board meeting. ~~*(3-30-01)*~~( )

02. Previous Complaints. A summary of previous complaints lodged against the provider. ~~*(3-30-01)*~~( )

03. Complaint Concerns. A copy and summary of the complainant's concerns. ~~*(3-30-01)*~~( )

04. Provider's Response. A copy and summary of the provider's response. ~~*(3-30-01)*~~( )

05. QAS Review. A summary of the QAS review of medical records/documentation~~:~~. ~~(3-30-01)~~( )

06. Copies of Documents. Additional ~~C~~copies of ~~the written complaint and response shall be attached to the summary. Other~~ documents may be attached as indicated by the nature of the complaint, response, and summary. ~~(3-30-01)~~( )

07. Summary of Additional Information. A copy and written summary of any additional interviews or information collected in the course of the investigation. ~~(3-15-02)~~( )

021. TRACKING.

~~After review by the Committee on Professional Discipline and/or t~~The Board ~~of Medicine~~, upon review and consideration of the recommendation made by the Committee on Professional Discipline (Committee) or respective Board or Committee, makes a determination upon the merits of the case and may take action to impose sanctions or limitations or conditions on licenses or permits issued: ~~(3-30-01)~~( )

01. Case Is Closed. If the Board determines to close~~d by the Board~~, the QAS shall correspond ~~with~~ in writing to the complainant and provider ~~and~~ notifying each of the Board's final determination and action ~~within the bounds of confidentiality~~ subject to federal and state law. ~~(3-30-01)~~( )

02. Further Investigation Is Requested. If the Board determines further investigation is ~~requested by the Board~~ necessary to fully adjudicate the case, the QAS shall obtain the requested information and prepare a summary as described in Section 020. The complainant and provider shall be notified in writing of the Board determination and the case's status ~~of the complaint~~. ~~(3-30-01)~~( )

03. Consultant Is Requested. If the Board determines a medical consultant is ~~requested by the Board~~ necessary to fully adjudicate the case, the QAS shall ~~request~~ engage an appropriate medical consultant~~,~~ to review the ~~recently retired or currently in~~ case and submit a ~~clinical practice similar to the physician under review, to review the information provided and prepare a~~ written report of findings to the Board. Such medical consultant may be recently retired from or currently in a clinical practice similar to the named provider. The Board shall define the focus, scope and depth of the medical consultant's review. The medical consultant shall be: ~~(3-15-02)~~( )

a. Board certified; (3-15-02)

b. Free from ~~disqualifying information~~ current Board review such as no open complaints or pending formal action; and ~~(3-15-02)~~( )

c. Free from conflict~~ings~~s ~~or disqualifying interest~~ and disqualification. Medical consultants shall disqualify themselves and, on motion of any interested party may, on proper showing, be disqualified in any proceeding concerning which they have an actual conflict of interest or bias which interferes with their fair and impartial service. ~~(3-15-02)~~( )

d. The medical consultant must sign an independence statement before commencing

the review. ~~(3-15-02)~~( )

~~**04. Records Review Is Requested**. If a records review is requested, the Board will define the focus, scope and depth of the review.~~ ~~(3-30-01)~~

0~~5~~4. Stipulation and Order Is Issued. If the Board determines the case warrants issuance of a stipulation and order ~~is issued~~, a Board attorney shall generate the stipulation and order and submit to the named provider for signature. ~~t~~The QAS ~~will~~ shall complete the stipulation checklist as indicated by the nature of the stipulation, identify the monitoring requirements and establish a monitoring plan for the provider. ~~(3-30-01)~~( )

0~~6~~5. Other Disciplinary Action Directed. If the Board determines other disciplinary actions are ~~directed by the Board~~ warranted, the QAS ~~will~~ shall act under the guidance of the Executive Director and/or Board counsel. ~~(3-30-01)~~( )

0~~7~~6. Opportunity to Meet With Committee. ~~Before~~ The named provider shall be provided an opportunity to meet with the Committee or Board staff prior to the initiation of formal disciplinary proceedings~~, a person under investigation shall be provided an opportunity to meet with the Committee on Professional Discipline or its staff, at the discretion of the licensee~~. ~~(3-30-01)~~( )

0~~8~~7. Recording of Board Action. The QAS ~~will~~ shall update the database and the case file to reflect the Board's determination and action on the reviewed cases. ~~(3-30-01)~~( )

022. AUTHORITY TO CLOSE COMPLAINTS/CASES.
The ~~only individuals~~ Board is solely authorized to close complaints ~~files are the Committee of Professional Discipline and/or the Board of Medicine~~ and cases. All complaints and cases must be presented to the respective Board for consideration and ~~action~~ recommendation to the Board. ~~(3-30-01)~~( )

023. OTHER INDICATORS FOR INVESTIGATION.

01. Board Investigations. The Board may ~~initate~~ commence any investigation on its own initiative or on the basis on performance indicators. ~~(3-15-02)~~( )

02. Performance Indicators. Performance indicators that may be used include, but are not limited to: (3-15-02)

a. Frequent changes in geographical practice location. (3-15-02)

b. Number of inactive licenses held. (3-15-02)

c. Number of malpractice complaints. (3-15-02)

d. Number of complaints lodged with the Board. ~~(3-15-02)~~( )

e. Failure to receive specialty board certification. (3-15-02)

f. Changes in area/specialty of practice without formal retraining. (3-15-02)

g. Health status. (3-15-02)

h. ~~*Age.*~~ Illness. Mental or physical illness, including but not limited to, deterioration through the aging process, or loss of motor skill; or excessive use or abuse of drugs, including alcohol. ~~*(3-15-02)*~~( )

i. Prescribing practices. (3-15-02)

j. Physicians without hospital privileges or medical practice affiliation who are not routinely subject to peer review. (3-15-02)

k. ~~*Physician*~~ Provider performance and outcome data received from sources such as Professional Review Organizations. ~~*(3-15-02)*~~( )

l. Disciplinary reports from managed care organizations. (3-15-02)

m. Disciplinary reports by other state and government agencies. ~~*(3-15-02)*~~( )

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective on **July 1, 2013**, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 516 through 528**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director at (208) 334-3110 ext. 2476.

DATED this 25th day of October, 2012.

Sandra Evans, M.A. Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Telephone: (208) 334-3110 ext. 2476.
Fax: (208) 334-3262

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404, 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 October 17, 2012.

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:

During properly noticed public meetings, the BON has adopted the National Council of State Board's of Nursing (NCSBN) Consensus Model for regulation of advanced practice registered nurses (APRN). The Consensus Model mandates specific requirements for licensure and practice regarding such nurses and carries a specific implementation date. Legislation passed by the Idaho Legislature in 2012 (Senate Bill 1273), obligates the BON to specify the details of qualifications for an APRN (that is, the education, training, experience, credentialing, etc.) in BON rule. The legislation largely becomes effective on **July 1, 2013**. This rulemaking intends to promulgate rules on these issues to become effective along with the legislation on **July 1, 2013**, and consistent with the NCSBN implementation timeline. This rulemaking will affect the licensure and practice of an APRN by increasing the required educational level for new licensees (and provide a "grandfathering" provision); identifying both an APRN role and population focus of practice; modifying several definitions to reflect these changes; and eliminating a restriction on prescribing or dispensing medications, consistent with a change in a Board of Pharmacy statute.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is intended to implement legislation, effective July 1, 2013. The rulemaking will formally put into place mandated licensing and other provisions the Board of Nursing (BON) has already adopted.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the

following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director at (208) 334-3110 ext. 2476.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1201

271. DEFINITIONS RELATED TO ADVANCED PRACTICE REGISTERED NURSING.

01. Accountability. Means being answerable for one's own actions. (7-1-99)

02. Advanced Practice Registered Nurse. Means a registered nurse licensed in this state who has gained additional specialized knowledge, skills and experience through a graduate or post-~~basic~~ graduate program of study as defined herein and is authorized to perform advanced nursing practice, which may include acts of diagnosis and treatment, and the prescribing, administering and dispensing of therapeutic pharmacologic and non-pharmacologic agents, as defined herein. Advanced practice registered nurses shall include nurses licensed in the roles of certified nurse-midwi~~v~~fe~~s~~, clinical nurse specialist~~s~~, certified nurse practitioner~~s~~, and certified registered nurse anesthetist~~s~~. Advanced practice registered nurses, when functioning within the recognized scope of practice, assume primary responsibility for the care of their patients in diverse settings. This practice incorporates the use of professional judgment in the assessment and management of wellness and conditions appropriate to the advanced practice registered nurse's role, population focus and area of specialization. ~~(7-1-99)~~( )

03. Authorized Advanced Practice Registered Nurse. Means an advanced practice registered nurse authorized by the Board to prescribe and dispense pharmacologic and non-pharmacologic agents pursuant to Section 315 of these rules. (7-1-99)

04. Certification. Means recognition of the applicant's advanced knowledge, skills and abilities in a defined area of nursing practice by a national organization recognized by the Board. The certification process measures the theoretical and clinical content denoted in the advanced scope of practice, and is developed in accordance with generally accepted standards of validation and reliability. (7-1-99)

05. Certified Nurse-Midwife. Means a licensed registered nurse who has graduated from a nationally accredited graduate or post-graduate nurse-midwifery program, ~~*passed a qualifying examination recognized by the Board*~~ and has current ~~*initial*~~ certification ~~*or current recertification*~~ as a nurse-midwife from a national organization recognized by the Board. ~~*(7-1-99)*~~( )

06. Certified Nurse Practitioner. Means a licensed registered nurse who has graduated from a nationally accredited graduate or post-graduate nurse practitioner program and has current certification as a nurse practitioner from a national organization recognized by the Board. ( )

07. Certified Registered Nurse Anesthetist. Means a licensed registered nurse who has graduated from a nationally accredited graduate or post-graduate nurse anesthesia program and has current certification as a nurse anesthetist from a national organization recognized by the Board. ( )

0~~6~~8. **Clinical Nurse Specialist**. Means a licensed registered nurse who has graduated from a nationally accredited graduate ~~*program in nursing with a*~~ or post-graduate clinical ~~*focus, passed a qualifying examination recognized by the Board*~~ nurse specialist program and has current ~~*initial*~~ certification ~~*or current recertification*~~ as a clinical nurse specialist from a national organization recognized by the Board. ~~*(7-1-99)*~~( )

0~~7~~9. **Collaboration**. Means the cooperative working relationship with another health care provider, each contributing his respective expertise in the provision of patient care, and such collaborative practice includes the discussion of patient treatment and cooperation in the management and delivery of health care. (7-1-99)

~~*08*~~10. **Consultation**. Means conferring with another health care provider for the purpose of obtaining information or advice. (7-1-99)

~~*09*~~11. **Diagnosis**. Means identification of actual or potential health problems and the need for intervention based on analysis of data collected. Diagnosis depends upon the synthesis of information obtained ~~*during the*~~ through interview, physical exam, ~~*or*~~ diagnostic tests or other investigations. ~~*(7-1-99)*~~( )

1~~0~~2. **Intervention**. Means measures to promote health, protect against disease, treat illness in its earliest stages, manage acute and chronic illness, and treat disability. Interventions may include, but are not limited to ordering diagnostic studies, performing direct nursing care, prescribing pharmacologic or non-pharmacologic or other therapies and consultation with or referral to other health care providers. (7-1-99)

~~***11. Nurse Practitioner.*** *Means a licensed registered nurse who has graduated from a nationally accredited nurse practitioner program, passed a qualifying examination recognized by the Board, and has current initial certification or current recertification as a nurse practitioner from a national organization recognized by the Board.* *(7-1-99)*~~

1~~2~~3. **Peer Review Process**. The systematic process by which ~~*one*~~ a qualified peer assesses, monitors, and makes judgments about the quality of care provided to patients ~~*by other*~~

~~peers~~ measured against established practice standards. Peer review: ~~(3-30-07)~~( )

a. Measures on-going practice competency of the advance practice registered nurse (APRN); (3-30-07)

b. Is performed by a licensed APRN, physician, ~~PA~~ physician assistant, or other professional certified by a recognized credentialing organization; and ~~(3-30-07)~~( )

c. Focuses on a mutual desire for quality of care and professional growth incorporating attitudes of mutual trust and motivation. (3-30-07)

14. Population Focus. Means the section of the population which the APRN has targeted to practice within. The categories of population foci are: ( )

a. Family/individual across the lifespan; ( )

b. Adult-gerontology; ( )

c. Women's health/gender-related; ( )

d. Neonatal; ( )

e. Pediatrics; and ( )

f. Psychiatric-mental health. ( )

1~~3~~5. Prescriptive and Dispensing Authorization. Means the legal permission to prescribe, deliver, distribute and dispense pharmacologic and non-pharmacologic agents to a client in compliance with Board rules and applicable federal and state laws. Pharmacologic agents include legend and Schedule II through V controlled substances. (7-1-99)

1~~4~~6. Referral. Means directing a client to a physician or other health professional or resource. (7-1-99)

~~***15. Certified Registered Nurse Anesthetist.*** *Means a licensed registered nurse who has graduated from a nationally accredited nurse anesthesia program, passed a qualifying examination recognized by the Board and has current initial certification or current recertification as a nurse anesthetist from a national organization recognized by the Board.*~~
~~*(7-1-99)*~~

1~~6~~7. Scope of Practice of Advanced Practice Registered Nurse. Means those activities that the advanced practice registered nurse may perform. Those activities shall be defined by the Board according to the advanced practice registered nurse's education, preparation, experience and the parameters set forth by the advanced practice registered nurse's recognized, national certifying organization. (7-1-99)

1~~7~~8. Specialization. Means ~~*focusing the advanced*~~ a more focused area of preparation and practice ~~*registered nurse's clinical area*~~ than that of ~~*practice, including but not limited to,*~~

~~*family health, mental health, child health, gerontological health, adult health or other*~~ the APRN role/population foci that is built on established criteria for recognition as a nursing specialty to include, but not limited to, specific patient populations (e.g., elder care, care of post-menopausal women), and specific health care needs (e.g., palliative care, pain management, nephrology). ~~*(7-1-99)*~~( )

272. -- 279. (RESERVED)

280. STANDARDS OF PRACTICE FOR ADVANCED PRACTICE REGISTERED NURSING.

01. Purpose. (7-1-99)

a. To establish standards essential for safe practice by the advanced practice registered nurse; and (7-1-99)

b. To serve as a guide for evaluation of advanced practice registered nursing to determine if it is safe and effective. (7-1-99)

02. Core Standards for All ~~*Categories*~~ Roles of Advanced Practice Registered Nursing. The advanced practice registered nurse is a licensed independent practitioner who shall practice ~~*in a manner*~~ consistent with the definition of advanced practice registered nursing, recognized national standards and the standards set forth in these rules. ( )

a. The advanced practice registered nurse ~~*may*~~ shall provide client services for which the advanced practice registered nurse is educationally prepared and for which competence has been ~~*attained*~~ achieved and maintained. ~~*(7-1-99)*~~( )

~~***a.*** *The advanced practice registered nurse shall consult and collaborate with other members of the health care team.* *(7-1-99)*~~

b. The advanced practice registered nurse shall recognize his limits of knowledge and experience and shall consult and collaborate with and refer to other health care professionals as appropriate. (7-1-99)

~~***c.*** *The advanced practice registered nurse shall retain professional accountability for advanced practice registered nursing care according to the advanced practice registered nurse's scope of practice and Subsections 400.01 and 400.02 of these rules.* *(7-1-99)*~~

~~***d***~~**c.** The advanced practice registered nurse shall evaluate and apply current evidence-based research findings relevant to the advanced nursing practice ~~*category*~~ role. ~~*(7-1-99)*~~( )

~~***e***~~**d.** The advanced practice registered nurse shall ~~*assess clients, identify problems or conditions, establish diagnoses, develop*~~ assume responsibility and ~~*implement treatment plans*~~ accountability for health promotion and ~~*evaluate patient outcomes*~~ maintenance as well as the assessment, diagnosis and management of client conditions to include the use of pharmacologic and non-pharmacologic interventions and the prescribing and dispensing of pharmacologic and non-pharmacologic agents. ~~*(7-1-99)*~~( )

~~f~~e. The advanced practice registered nurse shall use advanced practice knowledge and skills in teaching and guiding clients and other health care team members. ~~(7-1-99)~~( )

~~g. The advanced practice registered nurse shall use critical thinking and independent decision-making, commensurate with the autonomy, authority and responsibility of the practice category.~~ ~~(7-1-99)~~

~~h~~f. The advanced practice registered nurse shall have knowledge of the statutes and rules governing advanced nursing practice, and ~~function~~ shall practice within the established ~~boundaries of~~ standards for the ~~appropriate~~ advanced nursing practice ~~category~~ role and population focus. ~~(7-1-99)~~( )

g. The advanced practice registered nurse shall practice consistent with Subsections 400.01 and 400.02 of these rules. ( )

03. Certified Nurse-Midwife. In addition to the core standards, the advanced practice registered nurse~~s~~ in the ~~category~~ role of certified nurse midwife ~~shall practice in accord with standards established by~~ provides the ~~American College~~ full range of ~~Nurse Midwives Certifying Council or the American College of Nurse Midwives. Certified nurse-midwives who meet qualifying requirements and are licensed by the Board, may manage women's~~ primary health care ~~focusing on pregnancy, childbirth, the post-partum period, care of the newborn and reproductive and gynecological needs of well~~ services to women ~~as defined by~~ throughout the ~~certified nurse-midwife's scope of practice. The scope of practice of an authorized certified nurse-midwife may include prescribing~~ lifespan, including gynecologic care, family planning services, preconception care, prenatal and ~~dispensing pharmacologic~~ postpartum care, childbirth, care of the newborn and ~~non-pharmacologic agents~~ reproductive health care treatment of the male partners of female clients. ~~(4-6-05)~~( )

04. Clinical Nurse Specialist. In addition to ~~the~~ core standards, the advanced practice registered nurse~~s~~ in the ~~category~~ role of clinical nurse specialist ~~shall practice in accord with standards established by the American Nurses Credentialing Center. Clinical nurse specialists who meet qualifying requirements~~ provides services to patients, care providers and ~~are licensed by the Board, may practice as expert clinicians in a particular specialty or subspecialty of nursing practice. The clinical nurse specialist provides~~ health care delivery systems including, but not limited to, direct ~~client~~ care, ~~which may include assessing, diagnosing, planning, health promotion and preventive~~ expert consultation, care ~~within this specialized area of practice, as defined by the clinical nurse specialist's scope of practice. The scope of practice of an authorized clinical nurse specialist may include the prescribing and dispensing of pharmacologic~~ coordination, monitoring for quality indicators and ~~non-pharmacologic agents~~ facilitating communication between patients, their families, members of the health care team and components of the health care delivery system. ~~(4-6-05)~~( )

05. Certified Nurse Practitioner. In addition to ~~the~~ core standards, the advanced practice registered nurse~~s~~ in the ~~category~~ role of certified nurse practitioner ~~shall practice in accord with standards established by the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the National Association of Pediatric Nurse Associates~~ provides initial and ~~Practitioners or the Association of Women's Health Obstetrics and Neonatal Nurses.~~

~~*Certified nurse practitioners who meet qualifying requirements and are licensed by the Board may perform*~~ ongoing comprehensive ~~*health assessments,*~~ primary care services to clients including, but not limited to, diagnosis~~*, health promotion*~~ and ~~*the direct*~~ management of acute and chronic ~~*illness and*~~ disease~~*, as defined by the certified nurse practitioner's scope of practice. The scope of practice of an authorized certified nurse practitioner may include the prescribing and dispensing of pharmacologic*~~ and ~~*non-pharmacologic agents*~~ health promotion, disease prevention, health education counseling, and identification and management of the effects of illness on clients and their families. ~~*(4-6-05)*~~( )

06. Certified Registered Nurse Anesthetist. In addition to ~~*the*~~ core standards, the advanced practice registered nurse~~s~~ in the ~~*category*~~ role of certified registered nurse anesthetist ~~*shall practice in accord with standards established by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Certified registered nurse anesthetists who meet qualifying requirements and are licensed by the Board, may, in collaboration with a physician, dentist or podiatrist authorized to practice in Idaho,*~~ provides the full spectrum of anesthesia care and anesthesia-related care and services ~~*including selecting, ordering and administering medications as defined by national standards approved by*~~ to individuals across the ~~*Board. The scope of practice for authorized certified registered nurse anesthetists*~~ lifespan whose health status may ~~*include*~~ range across the ~~*prescribing*~~ wellness-illness continuum to include healthy persons; persons with immediate, severe or life-threatening illness or injury; and ~~*dispensing of pharmacologic agents*~~ persons with sustained or chronic health conditions. ~~*(7-1-99)*~~( )

07. Documentation of Specialization. Unless exempted under Section 305 of these rules, ~~*T*~~the advanced practice registered nurse must document competency within his specialty area of practice based upon education, experience and national certification in the ~~*specialty*~~ role and population focus. ~~*Nurse practitioners authorized to practice prior to July 1, 1998, must document competency within the specialty area of practice based upon education, experience and national certification in that specialty or education, experience and approval by the Board.*~~ ~~*(7-1-99)*~~( )

281. -- 284. (RESERVED)

285. QUALIFICATIONS FOR ADVANCED PRACTICE REGISTERED NURSE.
~~*An applicant for licensure as an advanced practice registered nurse shall meet the following requirements:*~~ ~~*(7-1-99)*~~

~~***01. Certified Nurse Midwife Qualifications.***~~ To qualify as ~~*a certified*~~ an advanced practice registered nurse~~ *midwife*~~, an applicant shall provide evidence of: ~~*(7-1-99)*~~( )

~~***a***~~**01. Current Licensure**. Current licensure to practice as a registered nurse in Idaho; ~~*(7-1-99)*~~( )

~~***b***~~**02. Completion of Advanced Practice Registered Nurse Program**. Successful completion of a graduate or post-graduate advanced practice registered nurse~~ *midwifery*~~ program which is accredited by a national organization recognized by the Board; and ~~*(7-1-99)*~~( )

~~***c.***~~ ~~*Passing results on the certification examination administered by the American*~~

~~College of Nurse-Midwives; and~~ ~~(7-1-99)~~

~~d~~**03. National Certification**. Current national certification ~~as a nurse-midwife from the American College of Nurse-Midwives~~ by an organization recognized by the Board for the specified APRN role. ~~(7-1-99)~~( )

~~**02. Clinical Nurse Specialist Qualifications**. To qualify as a clinical nurse specialist, an applicant shall provide evidence of:~~ ~~(7-1-99)~~

~~**a.** Current licensure to practice as a registered nurse in Idaho;~~ ~~(7-1-99)~~

~~**b.** A master's or higher degree in nursing with clinical specialization from a program accredited by a national organization recognized by the Board;~~ ~~(7-1-99)~~

~~**c.** Passing results on a certification examination administered by an organization recognized by the Board; and~~ ~~(7-1-99)~~

~~**d.** Current national certification as a clinical nurse specialist in the designated nursing specialty from an organization recognized by the Board.~~ ~~(7-1-99)~~

~~**03. Certified Nurse Practitioner Qualifications**. To qualify as a certified nurse practitioner, an applicant shall provide evidence of:~~ ~~(7-1-99)~~

~~**a.** Current licensure to practice as a registered nurse in Idaho;~~ ~~(7-1-99)~~

~~**b.** Successful completion of a nurse practitioner program which is accredited by a national organization recognized by the Board;~~ ~~(7-1-99)~~

~~**c.** Passing results on the certification examination administered by an organization recognized by the Board; and~~ ~~(7-1-99)~~

~~**d.** Current national certification as a nurse practitioner from an organization recognized by the Board.~~ ~~(7-1-99)~~

~~**04. Certified Registered Nurse Anesthetist Qualifications**. To qualify as a certified registered nurse anesthetist, an applicant shall provide evidence of:~~ ~~(7-1-99)~~

~~**a.** Current licensure to practice as a registered nurse in Idaho;~~ ~~(7-1-99)~~

~~**b.** Successful completion of a nurse anesthetist program accredited by a national organization recognized by the Board;~~ ~~(7-1-99)~~

~~**c.** Passing results on the certification examination administered by the Council on Certification of Nurse Anesthetists; and~~ ~~(7-1-99)~~

~~**d.** Current national certification as a nurse anesthetist from the Council on Certification of Nurse Anesthetists, or current national recertification from the Council on Recertification of Nurse Anesthetists.~~ ~~(7-1-99)~~

286. -- 289. (RESERVED)

290. APPLICATION FOR LICENSURE -- ADVANCED PRACTICE REGISTERED NURSE.
The advanced practice registered nurse requesting licensure to practice as a certified nurse-midwife, clinical nurse specialist, certified nurse practitioner or certified registered nurse anesthetist must submit an application to the Board which includes: (7-1-99)

01. Application Form. Completed, notarized application form provided by the Board. (7-1-99)

02. Official Transcript. Official transcript ~~*from the*~~ verifying successful completion of a graduate or post-graduate advanced practice nursing education program ~~*verifying successful completion*~~ nationally accredited by an organization recognized by the Board. ~~*(7-1-99)*~~( )

03. National Certification. Verification of current national certification from ~~*the*~~ a Board-recognized APRN certifying ~~*agent; and*~~ organization. ~~*(7-1-99)*~~( )

~~***04. Enrollment in Continuing Competency Assessment Program.*** *In addition to verification of national certification, a certified nurse-midwife must submit proof of enrollment in the continuing competency assessment program of the American College of Nurse-Midwives which bears a current expiration date. At the end of five (5) years, the certified nurse-midwife must submit evidence of completion of the continuing competency requirement of the program.*~~
~~*(7-1-99)*~~

0~~5~~4. Fee. The fee ~~*prescribed*~~ specified in S~~*ubs*~~ection 901.~~*02*~~ of these rules.
~~*(3-30-07)*~~( )

0~~6~~5. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-6-05)

291. -- 294. (RESERVED)

295. TEMPORARY LICENSURE -- ADVANCED PRACTICE REGISTERED NURSE.
A temporary license to engage in advanced practice registered nursing ~~*as a certified nurse-midwife, clinical nurse specialist, nurse practitioner, or registered nurse anesthetist*~~ may be issued to the following: ~~*(7-1-99)*~~( )

01. Applicants Awaiting Initial Certification Examination Results. An otherwise qualified applicant who is eligible to take the first available certification examination following completion of an approved advanced practice registered nurse education program. Verification of registration to write a Board-recognized national certification examination must be received from the national certifying organization. (7-1-99)

a. Temporary licensure to practice shall be deemed to expire upon failure of the certification examination. An applicant who fails the national certification exam shall not engage in advanced practice registered nursing until such time as all requirements are met. (7-1-99)

b. An applicant who is granted a temporary license to practice as an advanced practice registered nurse must submit notarized results of the certification examination within ten (10) days of receipt. Failure to submit required documentation shall result in the immediate expiration of the temporary license. (7-1-99)

c. The temporary license of an applicant who does not write the examination on the date scheduled shall immediately expire and the applicant shall not engage in advanced practice registered nursing until such time as all requirements are met. (7-1-99)

02. Applicants Whose Certification Has Lapsed. A licensed registered nurse applying for re-entry into advanced registered nursing practice, who is required by the national certifying organization to meet certain specified practice requirements under supervision. The length of and conditions for temporary licensure shall be determined by the Board. (7-1-99)

03. Applicants Holding a Temporary Registered Nursing License. An advanced practice registered nurse currently authorized to practice advanced practice registered nursing in another ~~*state*~~ nursing jurisdiction upon issuance of a temporary license to practice as a registered nurse, and upon evidence of current ~~*initial*~~ certification ~~*or recertification*~~ as an advanced practice registered nurse from a Board-recognized national certifying organization. ~~*(7-1-99)*~~( )

04. Applicants Without Required Practice Hours. An advanced practice registered nurse who has not practiced the minimum required period of time during the renewal period may be issued a temporary license in order to acquire the required number of hours and demonstrate ability to safely practice. (7-1-99)

05. Application Processing. An APRN whose application has been received but is not yet complete may be issued a temporary license. (3-30-07)

06. Term of Temporary License. A temporary license expires at the conclusion of the term for which it is issued, or the issuance of a renewable license, whichever occurs earlier. (3-30-07)

296. -- 299. (RESERVED)

300. RENEWAL ~~*AND REINSTATEMENT*~~ OF ADVANCED PRACTICE REGISTERED NURSE LICENSE.
The advanced practice registered nurse license may be renewed every two (2) years as ~~*prescribed*~~ specified in ~~*the*~~ Section 54-1411, Idaho Code, provided that the advanced practice registered nurse: ~~*(7-1-99)*~~( )

01. Current Registered Nurse License. Maintains a current registered nurse license~~,~~ or privilege~~,~~ to practice in Idaho. ~~*(3-15-02)*~~( )

02. Evidence of Certification. Submits evidence of current APRN certification by a national organization recognized by the Board. ~~*(7-1-99)*~~( )

03. Evidence of Continuing Education. Provides documentation of thirty (30)

contact hours of continuing education during the renewal period, which shall include ten (10) contact hours in pharmacology if the nurse has prescriptive authority. Continuing education completed may be that required for renewal of national certification if documentation is submitted confirming the certifying organization's requirement is for at least thirty (30) contact hours. ~~*These contact hours may include the requirements identified in Paragraph 315.02.b. of these rules in a two (2) year period.*~~ ~~*(7-1-99)*~~( )

04. Hours of Practice. Attests, on forms provided by the Board, to a minimum of two hundred (200) hours of advanced registered nursing practice within the preceding two (2) year period. (7-1-99)

05. Fee. Pays the fee ~~*prescribed*~~ specified in S~~*ubs*~~ection 900~~*.05*~~ of these rules. ~~*(3-30-07)*~~( )

~~***06. Criminal Background Check.*** *Submits a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code.* *(4-6-05)*~~

0~~*7*~~6. **Peer Review Process**. Provides evidence, satisfactory to the Board, of ~~*completion of*~~ participation in a peer review process acceptable to the Board. ~~*Applies to:*~~ ~~*(4-6-05)*~~( )

~~***a.*** *CNM, Certified Nurse Midwife;* *(4-6-05)*~~

~~***b.*** *CNS, Clinical Nurse Specialist; and* *(4-6-05)*~~

~~***c.*** *CNP, Certified Nurse Practitioner.* *(4-6-05)*~~

0~~*8*~~7. **Exemption From Requirements**. Nurse practitioners not certified by a national organization recognized by the Board and approved prior to July 1, 1998 shall be exempt from the requirement set forth in Subsection 300.02 of these rules. (7-1-99)

301. REINSTATEMENT OF ADVANCED PRACTICE REGISTERED NURSE LICENSE.
An advanced practice registered nurse license may be reinstated as specified in Section 54-1411, Idaho Code, provided that the applicant: ( )

01. Current Registered Nurse License. Maintains a current registered nurse license or privilege to practice in Idaho. ( )

02. Evidence of Certification. Submits evidence of current APRN certification by a national organization recognized by the Board. ( )

03. Prior Board Order. Complies with the provisions of any Board order, if discipline had previously been imposed. ( )

04. Fee. Pays the fee specified in Section 900 of these rules. ( )

05. Criminal Background Check. Submits a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. ( )

06. Reinstatement Rules. Complies with any additional requirements for reinstatement under the applicable provisions of Sections 061 and 062 of these rules. ( )

30~~1~~2. -- 304. (RESERVED)

305. PERSONS EXEMPTED FROM ADVANCED PRACTICE REGISTERED NURSING LICENSE REQUIREMENTS.

01. Students. Nothing in these rules shall prohibit a registered nurse who holds a current license, or privilege, to practice in Idaho and who is enrolled as a matriculated student in a~~n~~ nationally accredited educational program for advanced practice registered nursing from practicing as an advanced practice registered nurse when such practice is an integral part of the advanced practice registered nurse curriculum. ~~(3-15-02)~~( )

02. Certified Nurse Practitioners Licensed Prior to July 1, 1998. A certified nurse practitioner authorized to practice prior to July 1, 1998 may satisfy the requirement of Section 280.07 of these rules by documenting competency within his specialty area of practice based upon education, experience and national certification in that specialty or education, experience and approval by the Board. ( )

03. Advanced Practice Registered Nurses Educated Prior to January 1, 2016. ( )

a. An applicant for APRN licensure who completed a nationally accredited undergraduate or certificate APRN program prior to January 1, 2016, does not need to meet the APRN graduate or post-graduate educational requirements for initial licensure contained within Section 285 of these rules. ( )

b. A person applying for APRN licensure in Idaho who: holds an existing APRN license issued by any nursing jurisdiction, completed his formal APRN education prior to January 1, 2016, and who meets all of the requirements for initial licensure contained within Sections 285 and 286 of these rules except for the APRN graduate or post-graduate educational requirement, may be issued an APRN license by endorsement if at the time the person received his APRN license in the other jurisdiction he would have been eligible for licensure as an APRN in Idaho. ( )

(BREAK IN CONTINUITY OF SECTIONS)

315. PRESCRIPTIVE AND DISPENSING AUTHORIZATION FOR ADVANCED PRACTICE REGISTERED NURSES.

01. Initial Authorization. An application for the authority to prescribe and dispense pharmacologic and non-pharmacologic agents may be made as part of initial licensure application or by separate application at a later date. Advanced practice registered nurses who complete their

APRN graduate or post-graduate educational program after December 31, 2015, will automatically be granted prescriptive and dispensing authority with the issuance of their Idaho license. ~~(7-1-99)~~( )

a. An advanced practice registered nurse who applies for authorization to prescribe pharmacologic and non-pharmacologic agents within the scope of practice for the advanced practice ~~category~~ role, shall: ~~(7-1-99)~~( )

i. Be currently licensed as an advanced practice registered nurse in Idaho; (7-1-99)

ii. Provide evidence of completion of thirty (30) contact hours of post-basic education in pharmacotherapeutics obtained as part of study within a formal educational program or continuing education program, ~~which are~~ related to ~~the applicant's~~ advanced nursing practice. ~~category scope of practice and include:~~ ~~(7-1-99)~~( )

~~(1) Pharmacokinetic principles and their clinical application;~~ ~~(7-1-99)~~

~~(2) The use of pharmacologic agents in the prevention of illness, restoration, and maintenance of health;~~ ~~(7-1-99)~~

~~(3) Federal and state laws relating to the purchasing, possessing, prescribing, administering, and disposing of pharmacologic and non-pharmacologic agents;~~ ~~(7-1-99)~~

~~(4) Prescription writing;~~ ~~(7-1-99)~~

~~(5) Drug selection, dosage and route of administration; and~~ ~~(7-1-99)~~

~~(6) Drug interactions.~~ ~~(7-1-99)~~

iii. Submit a completed, notarized application form provided by the Board; and (7-1-99)

iv. Remit fees prescribed in S~~ubs~~ection 901~~.05~~ of these rules. ~~(3-30-07)~~( )

b. Exceptions to the pharmacotherapeutic education may be approved by the Board. (7-1-99)

c. Prescriptions written by authorized advanced practice registered nurses shall comply with all applicable state and federal laws and be signed by the prescriber with the abbreviation for the applicable ~~category~~ role of advanced nursing practice, the identification number assigned by the Board and where applicable, the Idaho Board of Pharmacy controlled substance registration number and the federal Drug Enforcement Agency registration number. ~~(7-1-99)~~( )

~~**d.** Advanced practice registered nurse authorization shall expire and may be renewed at the same time as the advanced practice registered nurse license.~~ ~~(7-1-99)~~

~~**02. Authorization Renewal**. Authorization may be renewed provided the applicant:~~

~~(7-1-99)~~

~~**a.** Maintains a valid advanced practice registered nurse license; (7-1-99)~~

~~**b.** Has completed ten (10) contact hours of approved pharmacology-related continuing education in the twenty-four (24) months immediately preceding application for renewal; and (7-1-99)~~

~~**c.** Has not engaged in any act or omission in the exercise of prescriptive authority which demonstrates a threat to the public. (7-1-99)~~

0~~3~~2. Temporary Authorization. The Board may grant temporary prescriptive authority to an applicant who holds a temporary advanced practice registered nurse license and who meets the requirements for initial authorization pursuant to Subsection 315.01 of these rules. (7-1-99)

0~~4~~3. Expiration of Temporary Prescriptive Authorization. Temporary prescriptive authorization automatically expires on the expiration, revocation, suspension, placement on probation, or denial of any advanced practice registered nurse license. (7-1-99)

0~~5~~4. Prescribing and Dispensing Authorization. All authorized advanced practice registered nurses may prescribe and dispense pharmacologic and non-pharmacologic agents pursuant to applicable state and federal laws~~, subject to the following conditions:~~. ~~(7-1-99)~~( )

~~a~~05. Valid Advanced Practice Registered Nurse/Patient Relationships. ( )

a. An advanced practice registered nurse shall not dispense pharmacologic agents except in the course of his professional practice and when a bona fide advanced practice registered nurse/patient relationship has been established. A valid relationship will exist when the advanced practice registered nurse has obtained sufficient knowledge of the patient's medical condition through examination and has assumed responsibility for the health care of the patient. ~~(7-1-99)~~( )

b. ~~Restrictions on the Dispensing of Controlled Substances.~~ A valid advanced practice registered nurse/patient relationship is not required when ~~D~~dispensing ~~of Schedule II controlled substances shall be limited to emergency periods to be determined on the basis of individual~~ or prescribing medications under the circumstances set forth at Section 54-1733(4), Idaho Code. ~~The emergency period will extend only until the Schedule II prescription can be filled from a pharmacy.~~ ~~(7-1-99)~~( )

~~**06. Accountability**. The advanced practice registered nurse when exercising prescriptive and dispensing authority is accountable for: (7-1-99)~~

~~**a.** Patient selection; (7-1-99)~~

~~**b.** Problem identification through appropriate assessment; (7-1-99)~~

~~**c.** Medication and device selection; (7-1-99)~~

~~***d.*** *Patient education for use of therapeutics;* *(7-1-99)*~~

~~***e.*** *Knowledge of interactions of therapeutics;* *(7-1-99)*~~

~~***f.*** *Evaluation of outcome; and* *(7-1-99)*~~

~~***g.*** *Recognition and management of complications and untoward reactions.* *(7-1-99)*~~

(BREAK IN CONTINUITY OF SECTIONS)

~~***317. SUMMARY SUSPENSION OF ADVANCED PRACTICE REGISTERED NURSE PRESCRIPTIVE AUTHORIZATION.***~~
~~*Failure to maintain active licensure as an advanced practice registered nurse shall result in the summary suspension of prescriptive authorization.* *(3-30-07)*~~

31~~8~~7. -- 319. (RESERVED)

320. RECOGNITION OF NATIONAL CERTIFYING ORGANIZATIONS FOR ADVANCED PRACTICE REGISTERED NURSING.

~~***01. Recognition of Certification.***~~ The Board recognizes advanced practice registered nurse certification ~~*by the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, the American College of Nurse-Midwives Certification Council (or the American College of Nurse-Midwives), the American Nurses Credentialing Center, the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, the National Certification Board of Pediatric Nurse Practitioners and Nurses, and the American Academy of Nurse Practitioners*~~ organizations that meet criteria as defined by the National Council of State Boards of Nursing. ~~*(7-1-99)*~~( )

~~***02. Continuing Recognition.*** *The Board may review and evaluate the certification process of Board-recognized national certifying agents for continuing recognition.* *(7-1-99)*~~

~~***03. Discontinuance of Recognition.*** *The Board may discontinue recognition of certifying agents should the Board determine that a certifying agent's certification process does not provide an accurate evaluation of the individual's ability to engage in the safe practice of advanced practice registered nursing.* *(7-1-99)*~~

~~***04. Review of Standards.*** *The Board may review and evaluate standards for advanced practice registered nursing established by recognized national certifying organizations.* *(7-1-99)*~~

~~***05. Recognition Criteria.*** *The Board may consider recognition of national certifying organizations according to the following criteria:* *(7-1-99)*~~

~~***a.*** *The national certifying body:* *(7-1-99)*~~

~~*i. Is national in the scope of its credentialing;* (7-1-99)~~

~~*ii. Has no requirement for an applicant to be a member of any organization;* (7-1-99)~~

~~*iii. Has educational requirements which are consistent with the requirements of these rules;* (7-1-99)~~

~~*iv. Has an application process and credential review which includes documentation that the applicant's education is in the advanced nursing practice category being certified, and that the applicant's clinical practice is in the certification category;* (7-1-99)~~

~~*v. Uses an examination as a basis for certification in the advanced nursing practice category which meets the following criteria:* (7-1-99)~~

~~*(1) The examination is based upon job analysis studies conducted using standard methodologies acceptable to the testing community;* (7-1-99)~~

~~*(2) The examination represents entry-level practice in the advanced nursing practice category;* (7-1-99)~~

~~*(3) The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to the clients;* (7-1-99)~~

~~*(4) The examination content and its distribution are specified in a test plan, based on the job analysis study, that is available to examinees;* (7-1-99)~~

~~*(5) Examination items are reviewed for content validity, cultural sensitivity and correct scoring using an established mechanism, both before use and periodically;* (7-1-99)~~

~~*(6) Examination items are evaluated for psychometric performance;* (7-1-99)~~

~~*(7) The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically; and* (7-1-99)~~

~~*(8) Examination security is maintained through established procedures.* (7-1-99)~~

~~*vi. Issues certification based upon passing the examination and meeting all other certification requirements;* (7-1-99)~~

~~*vii. Provides for periodic re-certification which includes review of qualifications and continued competence;* (7-1-99)~~

~~*viii. Has mechanisms in place for communication to the Board for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice; and* (7-1-99)~~

~~*ix. Has an evaluation process to provide quality assurance in its certification*~~

~~*program.*~~ ~~*(7-1-99)*~~

321. -- 389. (RESERVED)

390. USE OF TITLES, ABBREVIATIONS, AND DESIGNATIONS FOR THE PRACTICE OF NURSING.

01. Title for Graduates. A new graduate issued a temporary license pursuant to Section 040 of these rules shall use the title graduate nurse, abbreviated G.N., or graduate practical nurse, abbreviated G.P.N., or graduate nurse midwife, abbreviated G.N.M., or graduate clinical nurse specialist, abbreviated G.C.N.S., or graduate nurse practitioner, abbreviated G.N.P., or graduate nurse anesthetist, abbreviated G.N.A., whichever is appropriate, until the renewable license is issued. (3-30-07)

02. Titles. An individual who has successfully met all requirements for licensure as an advanced practice registered nurse shall have the right to use the title corresponding to the ~~*category*~~ role of advanced nursing practice for which the individual is licensed. ~~*(7-1-99)*~~( )

a. Title of Certified Nurse-Midwife. Individuals who have successfully met all requirements for licensure as a certified nurse-midwife shall have the right to use the title certified nurse-midwife, abbreviated APRN, CNM. ~~*(7-1-99)*~~( )

b. Title of Clinical Nurse Specialist. Individuals who have successfully met all requirements for licensure as a clinical nurse specialist shall have the right to use the title clinical nurse specialist, abbreviated APRN, CNS. ~~*(7-1-99)*~~( )

c. Title of Certified Nurse Practitioner. Individuals who have successfully met all requirements for licensure as a certified nurse practitioner shall have the right to use the title certified nurse practitioner, abbreviated APRN, CNP. ~~*(7-1-99)*~~( )

d. Title of Certified Registered Nurse Anesthetist. Individuals who have successfully met all requirements for licensure as a certified registered nurse anesthetist shall have the right to use the title certified registered nurse anesthetist, abbreviated APRN, CRNA. ~~*(7-1-99)*~~( )

03. Registered Nurse Title. Individuals who have successfully met all requirements for licensure as registered nurse~~*s*~~ shall have the right to use the title Registered Nurse, abbreviated R.N. ~~*(5-21-79)*~~( )

04. Licensed Practical Nurse Title. Individuals who have successfully met all requirements for licensure as a practical nurse~~*s*~~ shall have the right to use the title Licensed Practical Nurse, abbreviated L.P.N. ~~*(5-21-79)*~~( )

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 529 through 542**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director at (208) 334-3110 ext. 2476.

DATED this 25th day of October, 2012.

Sandra Evans, M.A. Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Telephone: (208) 334-3110 ext. 2476.
Fax: (208) 334-3262

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404, 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 October 17, 2012.

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 rulemaking is necessary to correct inaccurate citations; to update the rules to incorporate changes to Uniform Licensing Requirements promulgated by the National Council of State Boards that have been adopted by the Board; and to clarify several Board rules. This rulemaking will correct inaccurate citations to both a Board statute and rule; eliminate an unnecessary restriction in a definition; add a definition; eliminate an antiquated exemption applicable to taking the licensing examination; clarify an English proficiency requirement; and simplify other wording to obtain clarity.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the portion of this rulemaking that addresses proficiency by license applicants in English is mandated by Uniform Licensing Requirements (ULR) for nurses already endorsed and adopted by the Board of Nursing in noticed public meetings. This part of the rulemaking is simply formalizing in rule those requirements. The rest of the rulemaking is essentially “housekeeping” or simple in nature in that it corrects typographical or citation errors, changes a couple of definitions to conform to statute, and makes other minor non-controversial changes.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, M.A. Ed., R.N., Executive Director at (208) 334-3110 ext. 2476.

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 October 24, 2012.

DATED this 29th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1202

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Section 54-1404(1~~1~~3), Idaho Code. ~~(3-30-07)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Abandonment. The termination of a nurse/patient relationship without first making appropriate arrangements for continuation of required nursing care. The nurse/patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse. Refusal to accept an employment assignment or refusal to accept or begin a nurse/patient relationship is not abandonment. Reasonable notification, or a timely request for alternative care for a patient, directed to ~~*an attending physician*~~ a qualified provider or to a staff supervisor, prior to leaving the assignment, constitutes termination of the nurse/patient relationship.
~~(3-30-07)~~( )

02. Accreditation. The official authorization or status granted by a recognized accrediting entity or agency other than a state board of nursing. (7-1-93)

03. Administration of Medications. The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of medication is a complex nursing responsibility which requires a knowledge of anatomy, physiology, pathophysiology, and pharmacology. Only persons authorized under Board statutes and these rules may administer medications and treatments as prescribed by health care providers authorized to prescribe medications. (4-7-11)

04. Approval. The process by which the Board evaluates and grants official recognition to education programs that meet standards established by the Board. (5-3-03)

05. **Assist**. To aid or help in the accomplishment of a prescribed set of actions. (7-1-93)

06. **Assistance With Medications**. The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a patient who cannot independently self-administer medications. (5-3-03)

07. **Board**. The Idaho Board of Nursing. (7-1-93)

08. **Board Staff**. The executive director and other such personnel as are needed to implement the Nursing Practice Act and these rules. (7-1-93)

09. **Charge Nurse**. A licensed nurse who bears primary responsibility for assessing, planning, prioritizing and evaluating care for the patients on a unit, as well as the overall supervision of the licensed and unlicensed staff delivering the nursing care. (5-3-03)

10. **Clinical Preceptor**. A licensed registered nurse who acts to facilitate student training in a manner prescribed by a written agreement between the preceptor's employer and an educational institution. (5-3-03)

11. **Competence**. Safely performing those functions within the role of the licensee in a manner that demonstrates essential knowledge, judgment and skills. (5-3-03)

12. **Curriculum**. The systematic arrangement of learning experiences including didactic courses, practical experiences, and other activities needed to meet the requirements of the nursing program and of the certificate or degree conferred by the parent institution. (5-3-03)

13. **Delegation**. The process by which a licensed nurse assigns tasks to be performed by others. (5-3-03)

14. **Disability**. Any physical, mental, or emotional condition that interferes with the nurse's ability to practice nursing safely and competently. (5-3-03)

15. **Emeritus License**. A license issued to a nurse who desires to retire from active practice for any length of time. (5-3-03)

16. **Licensing Examination**. A licensing examination that is acceptable to the Board. (5-3-03)

17. **License in Good Standing**. A license not subject to current disciplinary action, restriction, probation or investigation in any jurisdiction. (5-3-03)

18. **Limited License**. A nursing license subject to specific restrictions, terms, and conditions. (5-3-03)

19. **Nursing Assessment**. The systematic collection of data related to the patient's health care needs. (5-3-03)

20. Nursing Diagnosis. The clinical judgment or conclusion regarding patient/client/ family/ community response to actual or potential health problems made as a result of the nursing assessment. (7-1-93)

21. Nursing Intervention. An action deliberately selected and performed to support the plan of care. (5-3-03)

22. Nursing Jurisdiction. Unless the context clearly denotes a different meaning, when used in these rules, the term nursing jurisdiction shall mean any or all of the fifty (50) states, U.S. territories or commonwealths, as the case may be. ( )

2~~2~~3. Nursing Service Administrator. A licensed registered nurse who has administrative responsibility for the nursing services provided in a health care setting. (7-1-93)

2~~3~~4. Organized Program of Study. A written plan of instruction to include course objectives and content, teaching strategies, provisions for supervised clinical practice, evaluation methods, length and hours of course, and faculty qualifications. (7-1-93)

2~~4~~5. Patient. An individual or a group of individuals who are the beneficiaries of nursing services in any setting and may include client, resident, family, community. (5-3-03)

2~~5~~6. Patient Education. The act of teaching patients and their families, for the purpose of improving or maintaining an individual's health status. (5-3-03)

2~~6~~7. Plan of Care. The goal-oriented strategy developed to assist individuals or groups to achieve optimal health potential. (5-3-03)

2~~7~~8. Practice Standards. General guidelines that identify roles and responsibilities for a particular category of licensure and, used in conjunction with the decision-making model, define a nurse's relationship with other care providers. (5-3-03)

2~~8~~9. Probation. A period of time set forth in an order in which certain restrictions, conditions or limitations are imposed on a licensee. (5-3-03)

~~29~~30. Protocols. Written standards that define or specify performance expectations, objectives, and criteria. (5-3-03)

3~~0~~1. Revocation. Termination of the authorization to practice. (5-3-03)

3~~1~~2. Scope of Practice. The extent of treatment, activity, influence, or range of actions permitted or authorized for licensed nurses based on the nurse's education, preparation, and experience. (5-3-03)

3~~2~~3. Supervision. Designating or prescribing a course of action, or giving procedural guidance, direction, and periodic evaluation. Direct supervision requires the supervisor to be physically present and immediately accessible to designate or prescribe a course of action or to give procedural guidance, direction, and periodic evaluation. (4-6-05)

3~~3~~4. Suspension. An order temporarily withdrawing a nurse's right to practice nursing. (5-3-03)

3~~4~~5. Technician/Technologist. These individuals are not credentialed by regulatory bodies in Idaho and may include, but are not limited to: surgical, dialysis and radiology technicians/technologists, monitor technicians and medical assistants. (3-30-07)

3~~5~~6. Universal Standards. The recommendations published by the Center for Disease Control, Atlanta, Georgia, for preventing transmission of infectious disease, also referred to as "Standard Precautions." (5-3-03)

011. -- 039. (RESERVED)

040. TEMPORARY LICENSE.
A temporary license is a nonrenewable license. (3-30-07)

01. Issued at Discretion of Board. Temporary licenses are issued, and may be extended, at the discretion of the Board. (3-30-07)

02. Temporary Licensure by Interstate Endorsement. A temporary license may be issued to an applicant for interstate endorsement on proof of current licensure in good standing in another ~~*state*~~ nursing jurisdiction, satisfactory documentation of employment within the three (3) years immediately preceding application, and compliance with the requirements of Section 240 of these rules. ~~*(3-30-07)*~~( )

03. Temporary Licensure by Examination. A temporary license to practice nursing until notification of examination results and completion of criminal background check may be issued to an applicant for Idaho licensure following graduation from a nursing education program recognized by the professional licensing board for another nursing ~~*of any state or territory of the United States*~~ jurisdiction, and compliance with Section 221 of these rules. ~~*(3-30-07)*~~( )

a. The practice of nursing by new graduates holding temporary licensure shall be limited as follows: (3-30-01)

i. Direct supervision by a licensed registered nurse must be provided. (3-30-01)

ii. May not act as charge nurse. (5-3-03)

b. Temporary licenses issued to examination candidates will be issued for a period not to exceed three (3) months. (3-30-07)

04. Unsuccessful Examination Candidates. (6-11-93)

a. An applicant who fails to pass the licensing examination shall not be eligible for further temporary licensure. (3-30-01)

b. In the event that such applicant subsequently passes the licensing examination

after twelve (12) months or more have elapsed following completion of the educational program, a temporary license with conditions may be issued until verification of clinical competence is received. (3-30-01)

05. Applicants Not in Active Practice. A temporary license with specific terms and conditions may be issued to a person who has not actively engaged in the practice of nursing in any ~~state~~ nursing jurisdiction for more than three (3) years immediately prior to the application for licensure or to an applicant whose completed application indicates the need for confirmation of the applicant's ability to practice safe nursing. ~~(3-30-01)~~( )

06. Applicants from Other Countries. Upon final evaluation of the completed application, the Board may, at its discretion, issue a temporary license to a graduate from a nursing education program outside of ~~the United States or its territories~~ a nursing jurisdiction, pending notification of results of the licensing examination. ~~(6-11-93)~~( )

07. Fee. The applicant must pay the temporary license fee, as prescribed in Subsection 901.07 of these rules. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

076. PERSONS EXEMPTED BY BOARD.
Licensure to practice nursing shall not be required, nor shall the practice of nursing be prohibited for persons exempted by the Board including: (11-28-84)

01. Technicians and Technologists. Technicians and technologists who comply with Section 491 of these rules. (3-30-07)

02. Non-Resident Nurses. Non-resident nurses currently licensed in good standing in another ~~state or territory~~ nursing jurisdiction, who are in Idaho on a temporary basis because of enrollment in or presentation of a short term course of instruction recognized or approved by the Board and who are performing functions incident to formal instruction. ~~(3-30-07)~~( )

03. Family Members and Others. (7-1-93)

a. Family members providing care to a person to whom they are related by blood, marriage, adoption, legal guardianship or licensed foster care. (5-21-89)

b. Non-family members who provide gratuitous care to a person on a temporary basis in order to give respite to family members who regularly provide care to that person. (5-21-89)

c. Live-in domestics, housekeepers and companions provided they do not represent themselves as, nor receive compensation as, licensed nurses or other nursing care providers and so long as any health care provided is incidental to the services for which they are employed. (3-30-01)

04. Nurse Apprentice. A nurse apprentice is a currently enrolled nursing student who is employed for remuneration in a non-licensed capacity by a Board approved health care agency. (3-30-01)

a. Applicants for nurse apprentice shall: (3-30-01)

i. Be enrolled in an accredited/approved nursing education program that is substantially equivalent to Idaho's approved programs for practical/registered nursing. (6-20-92)

ii. Be in good academic standing at the time of application and notify the Board of any change in academic standing. (6-20-92)

iii. Meet the employing agency's health care skills validation requirements. (3-30-01)

iv. Satisfactorily complete a basic nursing fundamentals course. (3-30-01)

v. Use obvious designations that identify the applicant as a nurse apprentice. (3-30-01)

b. A completed application for nurse apprentice shall consist of: (3-30-01)

i. Completed application form provided by the Board, to include a fee of ten dollars ($10); and (7-1-93)

ii. Verification of satisfactory completion of a basic nursing fundamentals course; and (3-30-01)

iii. Validation of successful demonstration of skills from a nursing education program; and (3-30-01)

iv. Verification of on-going good academic standing in nursing education program. (3-30-01)

c. An individual whose application is approved shall be issued a letter identifying the individual as a nurse apprentice for a designated time period. (3-30-01)

d. A nurse apprentice may, under licensed registered nurse supervision, perform all functions approved by the Board for unlicensed assistive personnel as set forth in Section 490 of these rules. (3-30-07)

05. Employer Application. (3-30-01)

a. A completed application for health care agencies wishing to employ nurse apprentices shall consist of: (3-30-01)

i. Completed application form provided by the Board; (6-20-92)

ii. Job descriptions for apprentice; (3-30-01)

iii. A written plan for orientation and skill validation; (6-20-92)

iv. The name of the licensed registered nurse who shall be accountable and responsible for the coordination or management of the nurse apprentice program; (3-30-01)

v. Assurance that a licensed registered nurse is readily available when nurse apprentice is working; (3-30-01)

vi. A written procedure for the nurse apprentice who is asked to perform a task that could jeopardize a patient and who declines to perform the task; and (3-30-01)

vii. A fee of one hundred dollars ($100). (3-30-01)

b. Following application review, the Board may grant approval to a health care agency to employ nurse apprentices for a period of up to one (1) year. (3-30-01)

c. To insure continuing compliance with Board requirements, each approved agency shall submit an annual report to the Board on forms provided by the Board. Based on its findings, the Board may grant continuing approval annually for an additional one (1) year period.(6-20-92)

d. At any time, if the employing agency fails to inform the Board of changes in conditions upon which approval was based or otherwise fails to comply with established requirements, the Board may notify the agency of withdrawal of approval. (6-20-92)

077. MULTISTATE LICENSURE.

01. Definitions. In Section 077, the following terms have the meanings indicated. (3-15-02)

a. Board means the regulatory body responsible for issuing nurse licenses. (3-15-02)

b. Compact means the Nurse Multistate Licensing Compact. (3-15-02)

c. Coordinated Licensure Information System (CLIS) means an integrated process for collecting, storing, and sharing information on nurse licensing and enforcement activities related to nurse licensing laws, which is administered by a nonprofit organization composed of and controlled by state nurse licensing boards. (3-15-02)

d. Home state means the party state that is the nurse's primary state of residence. (3-15-02)

e. Party state means a state that is a signatory on the compact. (3-15-02)

f. Primary state of residence means the state of a person's declared fixed permanent and principal home for legal purposes; domicile. (3-29-10)

g. Public means an individual or entity other than designated staff or representatives

of party state boards or the National Council of State Boards of Nursing, Inc. (3-15-02)

02. Examination. No applicant may be issued a compact license granting a multistate privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX (National Council Licensure Examination) ~~examination~~: ~~(4-6-05)~~( )

a. NCLEX-RN for registered nursing; or (4-6-05)

b. NCLEX-PN for practical nursing. (4-6-05)

03. Issuance of License in Compact Party State. (3-15-02)

a. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. This evidence shall include a declaration signed by the licensee. Further evidence that may be requested includes, but is not limited to: (3-15-02)

i. Driver's license with a home address; (3-15-02)

ii. Voter registration card displaying a home address; (3-29-10)

iii. Federal income tax return declaring the primary state of residence; (3-29-10)

iv. Military Form No. 2058 - state of legal residence certificate; or (3-29-10)

v. W2 from U.S. Government or any bureau, division, or agency thereof, indicating the declared state of residence. (3-29-10)

b. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state. (3-29-10)

c. A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license. (3-29-10)

d. When a party state issues a license authorizing practice only in that state and not authorizing practice in other party states (i.e., a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance. (3-29-10)

e. A nurse changing primary state of residence, from one (1) party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days. (3-15-02)

f. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance, and the thirty (30) day period in Paragraph 077.03.~~b~~e. of these rules shall be stayed until resolution of the pending investigation. ~~(3-30-07)~~( )

g. The former home state license is not valid upon the issuance of a new home state license. (3-15-02)

h. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days, and the former home state will take action in accordance with that state's laws and regulations. (3-15-02)

04. Multistate Licensure Privilege Limitations. (3-15-02)

a. Home state boards shall include, in all disciplinary orders or agreements that limit practice or require monitoring, the requirement that the licensee subject to the order or agreement shall limit the licensee's practice to the home state during pendency of the disciplinary order or agreement. (3-15-02)

b. The requirement referred to in Paragraph 077.04.a. of these rules may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and other party state boards. (3-30-07)

c. An individual who had a license that was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued. (3-29-10)

05. Information System. (3-15-02)

a. Levels of Access. (3-15-02)

i. Public access to nurse licensure information shall be limited to: (3-15-02)

(1) The licensee's name; (3-15-02)

(2) Jurisdictions of licensure; (3-15-02)

(3) Licensure expiration date; (3-15-02)

(4) Licensure classification and status; (3-15-02)

(5) Public emergency, summary, and final disciplinary actions, as defined by contributing state authority; and (3-15-02)

(6) The status of multistate licensure privileges. (3-15-02)

ii. Non-party state boards shall have access to all CLIS data except current significant investigative information and other information as limited by contributing party state authority. (3-15-02)

iii. Party state boards shall have access to all CLIS data contributed by the party states and other information as allowed by contributing non-party state authority. (3-15-02)

b. Right to Review. (3-15-02)

i. The licensee may request, in writing, to the home state board to review data relating to the licensee in the CLIS. (3-15-02)

ii. If a licensee asserts that any data relating to the licensee is inaccurate, the burden of proof is on the licensee to provide evidence substantiating that claim. (3-15-02)

iii. Within ten (10) business days, the Board shall correct information that it finds to be inaccurate in the CLIS. (3-15-02)

c. Changes in Disciplinary Data. (3-15-02)

i. Within ten (10) business days, the Board shall report to CLIS: (3-15-02)

(1) Disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring unless the agreement or order relating to participation in alternative programs is required to remain nonpublic by the contributing state authority; (3-15-02)

(2) Dismissal of the complaint; and (3-15-02)

(3) Changes in status of disciplinary action, or licensure encumbrance. (3-15-02)

ii. The Board shall delete current significant investigative information from the CLIS within ten (10) business days after: (3-15-02)

(1) A disciplinary action; (3-15-02)

(2) An agreement or order requiring participation in alternative programs; (3-15-02)

(3) An agreement or agreements, which limit practice or require monitoring; or (3-15-02)

(4) Dismissal of a complaint. (3-15-02)

iii. The CLIS administrator shall make changes to licensure information in the CLIS within ten (10) business days upon notification by a board. (3-15-02)

078. -- 089. (RESERVED)

090. DENIAL OF LICENSE.

01. Grounds for Denial of License. (3-15-02)

a. Failure to meet any requirement or standard established by law or by rules adopted by the Board; or (3-15-02)

b. Failure to pass the licensing examination; or (3-15-02)

c. False representation of facts on an application for licensure; or (3-15-02)

d. Having another person appear in his place for the licensing examination; or (3-15-02)

e. Engaging in any conduct which would be grounds for discipline under Nursing Practice Act, Section 54-1413 (1), Idaho Code, or Sections 100 or 101 of these rules. (3-15-02)

f. Revocation, suspension, limitation, reprimand, voluntary surrender or any other disciplinary action or proceeding, including investigation against a license, certificate or privilege to practice by another ~~*state or*~~ nursing jurisdiction. ~~*(3-15-02)*~~( )

02. Notification of Denial. The Board shall give any applicant whose application for licensure is denied written notice containing a statement: (3-15-02)

a. That the applicant has failed to qualify to be examined or licensed; and (6-1-78)

b. A description of the reason for denial; and (3-15-02)

c. Directing the applicant's attention to his rights under Section 54-1413(3)(a), Idaho Code. (3-30-07)

03. Reapplication for a License After Previous Denial. (3-15-02)

a. Reapplication for a license previously denied must include evidence, satisfactory to the Board, of rehabilitation, or elimination or cure of the conditions for denial. (3-15-02)

b. Evaluation of reapplication for a license denied under Section 54-1413, Idaho Code, shall include consideration of at least the following factors: (3-15-02)

i. The nature and severity of the act or omission which resulted in the denial of license; (7-1-93)

ii. The conduct of the applicant subsequent to the denial of license; (7-1-93)

iii. The lapse of time since denial of license; (7-1-93)

iv. Compliance with any conditions the Board may have stipulated as a prerequisite for reapplication; (7-1-93)

v. The degree of rehabilitation attained by the applicant as evidenced by statements sent directly to the Board from qualified people who have professional knowledge of the applicant; and (7-1-93)

vi. Personal interview by the Board, at its discretion. (3-15-02)

c. Reapplication files will remain open and active for a period of twelve (12) months from date of receipt. After expiration of the twelve (12) months, the file will be closed and any subsequent reapplication will require submission of a new application form and payment of required fees. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

101. STANDARDS OF CONDUCT.

01. Violations. Any violation of these Standards of Conduct shall be grounds for disciplinary action in accordance with Section 54-1413(1), Idaho Code, of the Idaho Nursing Practice Act and Section 090 or 100 of these rules. (3-30-07)

02. Classification. For purposes of convenience only, the standards of conduct are grouped generally into one (1) of three (3) categories: license, practice, and professional responsibility. The fact that any particular standard is so classified in any particular category will not be relevant for any purpose other than ease of use. (3-15-02)

03. License. (3-15-02)

a. Period of Practice. The nurse shall practice registered or practical nursing in Idaho only with a current Idaho license or during the period of valid temporary licensure or as otherwise allowed by law. (3-15-02)

b. Aiding in Violation of Law. The nurse shall not aid, abet, or assist any other person to violate or circumvent laws or rules pertaining to the conduct and practice of nursing. (11-28-84)

c. Reporting Grossly Negligent or Reckless Practice. The nurse shall report to the Board any licensed nurse who is grossly negligent or reckless in performing nursing functions or who otherwise violates the Nursing Practice Act or the Board rules. (7-1-93)

d. Unlawful Use of License. The nurse shall not permit his license to be used by another person for any purpose or permit unlicensed persons under his jurisdiction or supervision to indicate in any way that they are licensed to perform functions restricted to licensed persons. (7-1-93)

e. Impairment of Ability. The nurse shall not practice nursing while the ability to practice is impaired by alcohol or drugs or physical, mental or emotional disability. (11-28-84)

04. Practice. (3-15-02)

a. Perform Acts. The nurse shall have knowledge of the statutes and rules governing nursing and shall function within the defined legal scope of nursing practice. The nurse shall not assume any duty or responsibility within the practice of nursing without adequate training or where competency has not been maintained. (3-15-02)

b. Delegating Activities to Others. The nurse shall delegate activities only to persons who are competent and qualified to undertake and perform the delegated activities and shall not delegate to non-licensed persons functions that are to be performed only by licensed nurses~~, to the detriment of patient safety~~. ~~(11-28-84)~~( )

c. Supervision. The nurse delegating functions shall supervise the persons to whom the functions have been assigned or delegated. (11-28-84)

d. Safeguarding Patient. The nurse shall act to safeguard the patient from the incompetent practice, verbal or physical abusive acts or illegal practice of any person. (7-1-93)

e. Prescription Drugs. The nurse shall not obtain, possess, furnish or administer prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs. (11-28-84)

f. Leaving Assignment. The nurse shall not abandon patients in need of nursing care in a negligent or wanton manner. The nurse shall leave a nursing assignment only after properly reporting and notifying appropriate personnel and shall transfer responsibilities to appropriate personnel or care giver when continued care is required by the patient's condition. (7-1-91)

g. Respecting Patient's Privacy. The nurse shall respect the patient's privacy. (7-1-91)

h. Confidentiality. The nurse shall not disseminate information about the patient to individuals not entitled to such information except where such information is required by law or for the protection of the patient. (7-1-91)

i. Observe and Report. The nurse shall observe the condition and signs and symptoms of a patient, record the information, and report to appropriate persons any significant changes. (7-1-91)

j. Collaboration. The nurse shall function as a member of the health team and shall collaborate with other health team members as necessary to meet the patient's health needs. (7-1-91)

k. Universal Standards. The nurse shall adhere to universal standards and carry out principles of asepsis and infection control and shall not place the patient, the patient's family or the nurse's coworkers at risk for the transmission of infectious diseases. (3-15-02)

05. Professional Responsibility. (3-15-02)

a. Disclosing Contents of Licensing Examination. The nurse shall not disclose contents of any licensing examination, or solicit, accept, or compile information regarding the contents of any examination before, during, or after its administration. (11-28-84)

b. Considerations in Providing Care. In providing nursing care, the nurse shall respect and consider the individual's human dignity, health problems, personal attributes, national origin, and handicaps and shall not discriminate on the basis of age, sex, race, religion, economic or social status or sexual preferences in the rendering of nursing services. (11-28-84)

c. Responsibility and Accountability Assumed. The nurse shall be responsible and accountable for his nursing judgments, actions and competence. (7-1-93)

d. Witnessing Wastage of Controlled Substances Medication. Controlled substances may not be wasted without witnesses. The nurse shall not sign any record as a witness attesting to the wastage of controlled substance medications unless the wastage was personally witnessed. The nurse shall not solicit the signatures on any record of a person as a witness to the wastage of a controlled substance when that person did not witness the wastage. The nurse shall solicit signatures of individuals who witnessed the wastage in a timely manner. (3-30-07)

e. Record-keeping. The nurse shall make or keep accurate, intelligible entries into records required by law, employment or customary practice of nursing, and shall not falsify, destroy, alter or knowingly make incorrect or unintelligible entries into patients' records or employer or employee records. (11-28-84)

f. Diverting or Soliciting. The nurse shall respect the property of the patient and employer and shall not take or divert equipment, materials, property, or drugs without prior consent or authorization, nor shall the nurse solicit or borrow money, materials or property from patients. (3-15-02)

g. Exploit, Solicit, or Receive Fees. The nurse shall not exploit the patient or the patient's family for personal or financial gain or offer, give, solicit, or receive any fee or other consideration for the referral of a patient or client. (3-15-02)

h. Professionalism. The nurse must not abuse the patient's trust. The nurse shall respect the dignity of the profession and maintain appropriate professional boundaries with respect to patients, the patients' families, and the nurse's coworkers. The nurse will not engage in violent, threatening or abusive behavior towards patients, patients' families or the nurse's coworkers. The nurse must be aware of the potential imbalance of power in professional relationships with patients, based on their need for care, assistance, guidance, and support, and ensure that all aspects of that relationship focus exclusively upon the needs of the patient. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

220. QUALIFICATIONS FOR LICENSURE BY EXAMINATION.

01. In-State. Individuals who have successfully completed all requirements for graduation from an Idaho nursing education program approved by the Board shall be eligible to

make application to the Board to take the licensing examination. (6-11-93)

02. Out-of-State. Individuals who hold a certificate of completion from a nursing education program having board of nursing approval in another ~~state or territory of the United States~~ nursing jurisdiction shall be eligible to make application to the Board to take the licensing examination, providing they meet substantially the same basic educational requirements as graduates of Idaho nursing education programs at the time of application. ~~(3-15-02)~~( )

03. Practical Nurse Equivalency Requirement. An applicant for practical nurse licensure by examination who has not completed an approved practical nurse program, must provide satisfactory evidence (such as official transcripts) of successful completion of nursing and related courses at an approved school preparing persons for licensure as registered nurses to include a course in personal and vocational relationships of the practical nurse. Related courses must be equivalent to those same courses included in a practical nursing program approved by the Board. (3-15-02)

04. Time Limit for Writing Examinations. Graduates who do not take the examination within twelve (12) months following completion of the nursing education program may be required to follow specific remedial measures as prescribed by the Board. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

240. QUALIFICATIONS FOR LICENSURE BY ENDORSEMENT.
An applicant for Idaho licensure by interstate endorsement must: (7-1-93)

01. Graduation Required. Be a graduate of a state approved/accredited practical or registered nursing education program that is substantially equivalent to Idaho's board-approved practical or registered nursing education program. Applicants for practical nurse licensure may also qualify under the provisions of Section 241 of these rules. (7-1-93)

02. Licensing Examination. Have taken the same licensing examination as that administered in Idaho and achieved scores established as passing for that examination by the Board~~, unless the applicant was licensed by examination prior to 1950~~. ~~(6-11-93)~~( )

03. Minimum Requirements. In lieu of the requirements in Subsections 240.01 and 240.02 of this rule, have qualifications that are substantially equivalent to Idaho's minimum requirements. (5-8-09)

04. Current Practice Experience. Have actively practiced nursing at least eighty (80) hours within the preceding three (3) years. (3-30-07)

05. License from Another ~~State or Territory~~ Nursing Jurisdiction. Hold a license in good standing from another ~~state or territory of the United States~~ nursing jurisdiction. The license of any applicant subject to official investigation or disciplinary proceedings shall not be considered in good standing. ~~(7-1-91)~~( )

241. LICENSURE BY EQUIVALENCY AND ENDORSEMENT LICENSURE.

01. Application by Equivalency. An applicant for practical nurse licensure by interstate endorsement based on equivalency must meet the following requirements: (3-30-07)

a. Licensing Examination. Have successfully taken the same licensing examination as that administered in Idaho; and (7-1-93)

b. License from Another ~~*State or Territory*~~ Nursing Jurisdiction. Hold a license in another ~~*state or territory*~~ nursing jurisdiction based on successful completion of nursing and related courses at an approved school preparing persons for licensure as registered nurses to include a course in personal and vocational relationships of the practical nurse (or equivalent experience) and additional courses equivalent to those same courses included in a practical nursing program approved by the Board, and provide evidence thereof. ~~(3-30-07)~~( )

02. Applicants Licensed in Another ~~*State or Territory*~~ Nursing Jurisdiction. Graduates of schools of nursing located outside the United States, ~~or~~ its territories or commonwealths who are licensed in a ~~*state or territory*~~ nursing jurisdiction and who meet the requirements of Subsections 240.02 through 240.05 of these rules may be processed as applicants for licensure by endorsement from another state. ~~(3-30-07)~~( )

03. Application for Licensure by Endorsement. A completed application for licensure by interstate endorsement must include all of the following: (7-1-93)

a. Application Form. Completed, notarized application form provided by the Board; (6-1-78)

b. Verification. Verification and documentation of licensure status from state of applicant's original licensure; (3-15-02)

c. Employment Reference. One (1) satisfactory nursing employment reference from the three (3) year period immediately preceding the application; (3-15-02)

d. Census Questionnaire. Completed Census Questionnaire; (6-1-78)

e. Fee. Payment of all required fees; and (3-15-02)

f. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-6-05)

242. -- 259. (RESERVED)

260. QUALIFICATIONS FOR LICENSURE OF GRADUATES OF SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES, ~~OR~~ ITS TERRITORIES, OR COMMONWEALTHS.

A graduate from a nursing education program outside of the United States, ~~or~~ its territories or commonwealths must: ~~(3-30-01)~~( )

01. Qualifications. Demonstrate nursing knowledge and ~~*written and spoken*~~ English proficiency skills in reading, writing, speaking and listening. ~~*(3-30-07)*~~( )

02. Education Credentials. Have education qualifications that are substantially equivalent to Idaho's minimum requirements at the time of application. (3-30-01)

03. License. Hold a license or other indication of authorization to practice in good standing, issued by a government entity or agency from a country outside the United States, ~~*or*~~ its territories or commonwealths. ~~*(3-30-07)*~~( )

04. Examination/Re-Examination. Take and achieve a passing score on the licensing examination required in Subsection 222.01 of these rules. (3-30-07)

261. APPLICATION FOR LICENSURE OF GRADUATES OF SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES, ~~*OR*~~ ITS TERRITORIES, OR COMMONWEALTHS.
A completed application for licensure by a graduate of a nursing education program outside of the United States, ~~*or*~~ its territories or commonwealths must include the following: ~~*(3-30-01)*~~( )

01. Verification. Verification of demonstrated nursing knowledge and ~~*written and spoken*~~ English proficiency skills in reading, writing, speaking and listening. ~~*(4-6-05)*~~( )

02. Application Form. Completed notarized application form provided by the Board. (6-1-78)

03. Official Transcript. Official transcript from the applicant's nursing education program, and certified translation if original transcript is not in English or completed equivalence credentials form issued by an organization acceptable to the Board. (3-30-01)

04. Verification of Licensure. Verification of licensure or other authority to practice from state, province, or country of applicant's original licensure. ~~*(6-1-78)*~~( )

05. Employment Reference. One (1) satisfactory nursing employment reference from the three (3) year period immediately preceding the application. (3-30-01)

06. Fee. Payment of the fee for licensure by examination. (3-30-01)

07. Criminal Background Check. A current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-6-05)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.06.01 - RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

DOCKET NO. 24-0601-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 551 through 556**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3717, 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 October 17, 2012.

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 Board of Occupational Therapists and Occupational Therapy Assistants is changing its rules to incorporate by reference the updated Certification Renewal Handbook published by the National Board for Certification in Occupational Therapy (NBCOT). The rule also clarifies close supervision and removes the requirement that two (2) CEU's must be recommended by the Idaho Occupational Therapy Association to reflect changes in the law.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are simple in nature and were discussed at scheduled noticed board meetings.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

Certification Renewal Handbook published by the National Board for Certification in Occupational Therapy (NBCOT) has been updated from the 2009 edition to the 2012 edition to update approved continuing education activities.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

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 October 24,

2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0601-1201

004. INCORPORATION BY REFERENCE.
The "PDU Activities Chart" on pages 14-17 of the document titled National Board for Certification in Occupational Therapy (NBCOT), Inc. Certification Renewal Handbook, 20~~09~~12, as published by the NBCOT, Inc. and copyrighted to NBCOT, Inc. in 20~~09~~12, which is referenced in Subsection 250.1.b. of these rules. All documents incorporated by reference are available at the Board's office and through the Board's website. ~~(3-29-10)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

011. SUPERVISION.
An occupational therapist shall supervise and be responsible for the patient care given by occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational therapists, student occupational therapy assistants, and aides. (3-29-10)

01. Skill Levels. The following skill levels apply to occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational therapists, student occupational therapy assistants and aides: (4-7-11)

a. Entry Level - Working on initial skill development (zero to one (0-1) year experience) or working in a new area of practice; (3-29-10)

b. Intermediate Level - Increased independence and mastery of basic roles and functions. Demonstrates ability to respond to new situations based on previous experience (generally one to five (1-5) years' experience); (3-29-10)

c. Advanced Level - Refinement of skills with the ability to understand complex issues and respond accordingly. (3-29-10)

02. Supervision Levels. The following supervision levels apply to occupational therapy assistants, graduate occupational therapists, graduate occupational therapy assistants, student occupational therapists, student occupational therapy assistants and aides: (4-7-11)

a. Direct Line of Site Supervision - An occupational therapist or occupational therapy assistant must provide direct line of site supervision to an aide; (3-29-10)

b. Direct Supervision - Daily, direct contact at the site of work with the supervisor physically present at all times within the facility when the supervisee renders care and requires the supervisor to co-sign all documentation that is completed by the supervisee. This supervision is the minimal level of supervision required for students, for entry or intermediate level occupational therapy assistants applying deep thermal and electrotherapeutic modalities, and for advanced level occupational therapy assistants who apply such modalities while lacking the education and training required in Subsection 012.01 of these rules; (4-7-11)

c. Close Supervision ~~- *Daily, direct contact at the site of work*~~. The occupational therapist provides daily direction in developing the plan of treatment and ~~*periodically*~~ inspects on-site the actual implementation of the plan at least every two (2) weeks. This supervision is the minimal level of supervision required for entry level occupational therapy assistants and graduate occupational therapy assistants; ~~*(4-7-11)*~~( )

d. Routine Supervision - Requires direct contact at least every two (2) weeks at the site of work, with interim supervision occurring by other methods, such as by telephone or written communication. This supervision is the minimal level of supervision required for graduate occupational therapists and intermediate level occupational therapy assistant. It also is the minimum level of supervision required for advanced level occupational therapy assistants applying deep thermal and electrotherapeutic modalities while possessing the education and training specified in Subsection 012.01 of these rules; (4-7-11)

e. General Supervision - Initial direction and periodic review of the following: service delivery, update of treatment plans, and treatment outcomes. The supervisor need not at all times be present at the premises where the occupational therapy assistant is performing the professional services. However, not less than monthly direct contact must be provided, with supervision available as needed by other methods. This supervision is the minimal level of supervision required for an intermediate to advanced occupational therapy assistant. (3-29-10)

03. Supervision Ratios. An occupational therapist may supervise up to three (3) full-time occupational therapy assistants, but never more than two (2) entry level occupational therapy assistants. The total number of supervised occupational therapy assistants, non-licensed occupational therapy personnel (including any graduate occupational therapists, graduate occupational therapy assistants, student occupational therapy, student occupational therapy assistants, and aides), and occupational therapists in training to provide deep thermal, electrotherapeutic modalities and wound care may not exceed five (5) without prior Board approval. The Board may permit the supervision of a greater number by an occupational therapist if, in the Board's opinion, there would be adequate supervision and the public's health and safety would be served. It is the supervising occupational therapist's responsibility to notify the Board of any circumstances requiring approval of a greater number and to submit a written plan for resolution of the situation. (4-7-11)

04. Record Keeping. The occupational therapy assistant, graduate occupational therapist, and graduate occupational therapy assistant must maintain on file at the job site signed documentation reflecting supervision activities. This supervision documentation must contain the following: date of supervision, means of communication, and information discussed. Both the supervising occupational therapist and the person being supervised must sign each entry. (4-7-11)

05. Occupational Therapy Assistants. Occupational Therapy Assistants may deliver occupational therapy services under the supervision of occupational therapists as follows. The occupational therapy assistant: (3-29-10)

a. May only select, implement, and modify therapeutic activities and interventions that are consistent with client goals, the requirements of the practice setting, and the occupational therapy assistant's demonstrated competency levels; (3-29-10)

b. Must not initiate a treatment program until the occupational therapist has evaluated the client and planned treatment for the client, or discharge the client from a treatment program without supervision from the occupational therapist; (3-29-10)

c. Must not perform an evaluation, but may contribute to the evaluation process with the supervision of the occupational therapist; (3-29-10)

d. May participate in the screening process by collecting data, such as records, by general observation and by conducting a general interview, and may communicate the information gathered to the occupational therapist; (3-29-10)

e. May track the need for reassessment, report changes in status that might warrant reassessment or referral, and administer the reassessment under the supervision of the occupational therapist; (3-29-10)

f. Must immediately discontinue any specific treatment procedure which appears harmful to the client, and so notify the occupational therapist; (3-29-10)

g. Is responsible for knowing about the client's targeted occupational therapy outcomes and for providing information and documentation related to outcome achievement; (3-29-10)

h. May implement outcome measurements and provide needed client discharge resources. (3-29-10)

06. Aides. Aides do not provide skilled occupational therapy services. An aide is trained by an occupational therapist or an occupational therapy assistant to perform specifically delegated tasks. The occupational therapist is responsible for the overall use and actions of the aide. An aide first must demonstrate competency to be able to perform the assigned, delegated client and non-client tasks. The occupational therapist must oversee the development, documentation, and implementation of a plan to supervise and routinely assess the ability of the occupational therapy aide to carry out non-client and client-related tasks. The occupational therapy assistant may contribute to the development and documentation of this plan. An aide shall function only under the direct line of sight supervision of an occupational therapist or occupational therapy assistant. An aide may provide: (3-29-10)

a. Non-client-related tasks, including clerical and maintenance activities and preparation of the work area or equipment. (3-29-10)

b. Client-related, routine tasks during which the aide may interact with the client. The following conditions must exist when an occupational therapist or occupational therapy assistant delegates a selected client-related task to the aide: (3-29-10)

i. The outcome anticipated for the delegated task is predictable. (3-29-10)

ii. The client and environment are stable and will not require that judgment, interpretations, or adaptations be made by the aide. (3-29-10)

iii. The client has demonstrated some previous performance ability in executing the task. (3-29-10)

iv. The task routine and process have been clearly established. (3-29-10)

v. The aide has been trained and is able to demonstrate competency in carrying out the task and in using any necessary equipment. (3-29-10)

vi. The aide has been instructed on how to specifically carry out the delegated task with the specific client. (3-29-10)

vii. The aide knows the precautions, signs, and symptoms for the particular client that would indicate the need to seek assistance from the occupational therapist or occupational therapy assistant. (3-29-10)

c. The supervision of the aide needs to be documented for every client-related activity performed by an aide. Documentation must include information about frequency and methods of supervision used, the content of supervision, and the names and credentials of all persons participating in the supervisory process. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

025. CONTINUING EDUCATION.
In order to protect public health and safety and promote the public welfare, the Board has adopted the following continuing education requirement consisting of both continuing education units (CEUs) and professional development units (PDUs): (3-29-10)

01. Requirement. Every two (2) years, a licensee must complete at least two (2) CEUs ~~*recommended by the Idaho Occupational Therapy Association and*~~ approved by the Board, along with at least ten (10) Board-approved professional development units (PDUs). The licensee's initial two (2) year period shall begin on the date on which this Board issues the licensee a license and end on the date on which the licensee submits the licensee's second renewal application. Thereafter, the two (2) year period shall begin to run from the date of each renewal application in which the licensee was required to verify the completion of continuing education.
~~*(3-29-10)*~~( )

a. A CEU is a measurement of the licensee's participation in a Board-approved continuing education activity. One (1) CEU requires ten (10) contact hours of participation in a Board-approved continuing education program, excluding meals and breaks. One (1) contact hour equals one (1) clock hour for purpose of obtaining CEUs. (3-29-10)

b. A PDU is a measurement of the licensee's participation in a professional development activity. One (1) contact hour of participation in Board-approved professional development activity equals one (1) PDU, one (1) academic credit equals ten (10) PDUs, and one (1) CEU equals ten (10) PDUs. If a licensee counts a CEU towards fulfilling the PDU requirement in a given two-year (2) period, the CEU unit will not count towards fulfilling the CEU requirement. Accepted PDU activities and their associated PDU values are set forth in the PDU Activities Chart at pages 14-17 of the NBCOT Certification Renewal Handbook, 2009 edition as incorporated by reference in Section 004. (3-29-10)

02. Verification. The licensee must verify to the Board, as part of the annual license renewal process, that the licensee is in compliance with the continuing education requirement. (3-29-10)

03. Courses and Activities. At least one (1) CEU and five (5) PDUs must directly relate to the delivery of occupational therapy services. The remaining PDUs and CEUs must be germane to the practice of occupational therapy and relate to other areas of a licensee's practice. A licensee may take online or home study courses, as long as a course completion certificate is provided. (3-29-10)

a. CEUs and PDUs acceptable to the Board include, but are not limited to, programs or activities sponsored by the American Occupational Therapy Association (AOTA) or the Idaho Occupational Therapy Association (IOTA); post-professional coursework completed through any approved or accredited educational institution that is not part of a course of study leading to an academic degree; or otherwise meet all of the following criteria: (3-29-10)

i. The program or activity contributes directly to professional knowledge, skill, and ability; (3-29-10)

ii. The program or activity relates directly to the practice of occupational therapy; and (3-29-10)

iii. The program or activity must be objectively measurable in terms of the hours involved. (3-29-10)

b. Partial credit will not be given for CEUs and PDUs. (3-29-10)

c. The delivery of occupational therapy services may include: models, theories or frameworks that relate to client/patient care in preventing or minimizing impairment, enabling function within the person/environment or community context. (3-29-10)

d. Other activities may include, but are not limited to, occupation based theory assessment/interview techniques, intervention strategies, and community/environment as related to one's practice (3-29-10)

04. Carry Over and Duplication. CEUs and PDUs cannot be carried over to the next reporting period. The same course taken more than once during a reporting cycle will only be counted once. (3-29-10)

05. Documentation. A licensee need not submit documentation of CEUs and PDUs when the licensee renews a license. However, a licensee must maintain documentation verifying that the licensee has completed the continuing education requirement for a period of four (4) years. A licensee must submit the verification documentation to the Board if the licensee is audited by the Board. A percentage of occupational therapists and certified occupational therapy assistants will be audited every year. (3-29-10)

a. Documentation for all activities must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of PDUs and CEUs. (3-29-10)

b. Records showing participation in each professional development activity must be maintained by the licensee. Acceptable documentation for specific activities includes: (3-29-10)

i. Continuing education course work. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)

ii. In-service training. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)

iii. Professional conference or workshop. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)

iv. Course work offered by an accredited college or university, provided that the course work is taken after the licensee has obtained a degree in occupational therapy, and the course work provides skills and knowledge beyond entry-level skills or knowledge. The required documentation for this activity is a transcript. (3-29-10)

v. Publications. The required documentation for this activity is a copy of the publication. (3-29-10)

vi. Presentations. The required documentation for this activity is a copy of the presentation or program listing. Any particular presentation may be reported only once per reporting period. (3-29-10)

vii. Interactive online courses. The required documentation for this activity is a certificate or documentation of completion. (3-29-10)

viii. Development of instructional materials incorporating alternative media such as video, audio and/or software programs to advance professional skills of others. The required documentation for this activity is a program description. The media/software materials must be available if requested during audit process. (3-29-10)

ix. Professional manuscript review. The required documentation for this activity is a letter from publishing organization verifying review of manuscript. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)

x. Guest lecturer for occupational therapy related academic course work (academia not primary role). The required documentation for this activity is a letter or other documentation from instructor. (3-29-10)

xi. Serving on a professional board, committee, disciplinary panel, or association. The required documentation for this activity is a letter or other documentation from the organization. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)

xii. Self study of cassette, tape, video tape, or other multimedia device, or book. The required documentation for this activity is a two (2) page synopsis of each item written by the licensee. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)

xiii. Level II fieldwork direct supervision of an occupational therapy student or occupational therapy assistant student by site designated supervisor(s). The required documentation for this activity is a name of student(s), letter of verification from school, and dates of fieldwork. A maximum of ten (10) hours per supervisor is allowed per reporting period for this category. (3-29-10)

06. Exemptions. A licensee may request an exemption from the continuing education requirement for a particular two-year (2) period under the following circumstances. The licensee must provide any information requested by the Board to assist in substantiating the licensee's need for a claimed exemption: (3-29-10)

a. During the continuing education period the licensee was residing in another country for one (1) year or longer, reasonably preventing completion of the continuing competency requirements; (3-29-10)

b. The licensee was absent from Idaho because of military service for a period of one (1) year or longer during the continuing education period, preventing completion of the continuing competency requirements; or (3-29-10)

c. The licensee should be exempt from the continuing competency requirements for reasons of health or other good cause. (3-29-10)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.10.01 - RULES OF THE STATE BOARD OF OPTOMETRY

DOCKET NO. 24-1001-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1509, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 557 through 565**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208*334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1509, 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 October 17, 2012.

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 State Board of Optometry is changing its rules to update, clarify and simplify Board procedures and processes. They also make changes based upon current industry standards and strike outdated language.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the February 1, 2012 Idaho Administrative Bulletin, **Vol. 12-2, Page 21**.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1001-1201

150. MEETING OF THE BOARD (RULE 150).
~~*Notice of all meetings not having been announced at the preceding meeting shall be given to each member of the Board by the secretary two (2) weeks in advance of such meeting. Such notice shall be in writing informing each member as to the time, place, and purpose of the meeting. In the event that written notice cannot be given two (2) weeks in advance, the chairman may instruct the secretary to notify each member of the Board either by telephone or telegraph as to the time, place and purpose of the meeting and any Board member who attends or participates in the meeting shall be deemed to have waived any objection to any notice required by the rules.*~~ The Board shall meet at least annually and at other such times and places as designated by the Chairman or upon written request of any two members of the Board. All meetings shall be held in accordance with the Idaho Open Meeting Law, Chapter 23, Title 67, Idaho Code. ~~*(7-1-93)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

175. METHOD OF APPLICATION-EXAMINATION OF APPLICANTS (RULE 175).
Applications for license shall be made on forms approved by the Board~~ *of Examiners which may be obtained and which must be filed in the office of Occupational License Bureau at Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702*~~. ~~*(3-30-01)*~~( )

01. Application ~~*Fee*~~. The application ~~*fee*~~ must be accompanied by: ~~*(7-1-93)*~~( )

a. The required fee. (7-1-93)

b. ~~*An unmounted photograph three inches by three inches (3" x 3"), head and shoulders only*~~ A passport style photograph, taken within one (1) year prior to the date of making the application. ~~*(7-1-93)*~~( )

c. A complete transcript of credits from any college of optometry attended. (7-1-93)

d. A photocopy of any diplomas granted by any college of optometry. (7-1-93)

e. A copy of certified results establishing successful passage of the required examinations. (3-30-01)

02. Application Review. Only fully completed applications accompanied by appropriate documents shall be reviewed for licensure. (3-30-01)

03. Exam Content. The written and the practical portions of the Idaho examination shall be all parts of the National Board of Examiners in Optometry Examination (NBEOE) and ~~*the "Treatment and Management of Ocular Diseases" examination approved by the Association*~~

~~of Regulatory Boards of Optometry, Inc. (ARBO)~~ the Board approved jurisprudence examination. A passing grade for the NBEOE shall be that established by the test provider. The passing grade for the jurisprudence examination shall be seventy-five percent (75%). A passing score on ~~both~~ all examinations shall be necessary ~~before obtaining~~ to qualify for a license to practice Optometry in Idaho. ~~(3-30-01)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

200. APPROVAL OF SCHOOLS OF OPTOMETRY (RULE 200).
The State Board of Optometry recognizes as reputable and in good standing the schools and colleges of optometry which have met the standards set by the Accreditation Council on Optometric Education ~~of the American Optometric Association~~, or its successor agency, a list of which may be obtained from the secretary of the Board or from the office of the Bureau of Occupational Licenses in Boise. ~~(7-1-93)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

300. CONTINUING EDUCATION IN OPTOMETRY (RULE 300).

01. Hours Required, Advance Approval. Each optometrist licensed by the state of Idaho shall attend in each twelve (12) month period preceding the renewal of a license to practice optometry in Idaho, a minimum of twelve (12) full hours of post-graduate optometric education courses or meetings approved in advance by the Board of Optometry or post-graduate study sessions or seminars at an accredited school or college of optometry. In addition, all Council on Optometric Practitioners Education (COPE) approved courses ~~would be~~ are approved for continuing education credit. If an optometrist attends or plans to attend a course of study or seminar which has not been approved in advance, he may petition the Board for approval of that educational course of study, setting forth a description of the course. The Board may, in its discretion, approve the course upon review of the material submitted either in advance or after completion of the course. ~~(8-24-94)~~( )

02. Additional Hours Required to Use Therapeutic Pharmaceutical Agents. Each optometrist licensed by the state of Idaho to use therapeutic pharmaceutical agents shall attend in each twelve (12) month period preceding the renewal of a license to practice optometry in Idaho, a minimum of six (6) additional full hours of post-graduate optometric courses or meetings approved in advance by the Board of Optometry or post-graduate study sessions or seminars at an accredited school or college of optometry. This six (6) hours of continuing education must be in courses involving ocular pharmacology and/or advanced ocular disease and are in addition to the twelve (12) hours of continuing education required under Subsection 300.01. (7-1-93)

03. Correspondence/Home Study Courses/Observation. The Board allows credit for correspondence courses, individual home study and observation that is germane to the practice

of optometry. No more than six (6) hours of continuing education shall be permitted each year in correspondence courses or other continuing education obtained from "home study" courses or observation. (3-30-07)

04. Waiver of Requirements. The Board of Optometry shall waive the continuing education requirement for the first license renewal after initial licensure. The Board of Optometry may, upon application, waive the requirements of this rule in cases involving illness, unusual circumstances interfering with the optometrist's ability to practice or inability to conform to the rules due to military duty. (3-15-02)

05. Renewal Application Form. Each licensed Idaho optometrist will be furnished a license renewal application form by the State Board of Optometry on which each optometrist shall attest on their annual license renewal application that they have satisfied the continuing education requirements. False attestation of satisfaction of the continuing education requirements on a renewal application shall subject the licensee to disciplinary action. (3-20-04)

06. Audit. The Board may conduct audits to confirm that the continuing education requirements have been met. In the event a licensee fails to provide the Board with acceptable documentation of the hours attested to on the renewal application, the license will not be renewed. (3-20-04)

07. Documentation of Attendance. It shall be necessary for each licensed Idaho optometrist to provide documentation verifying attendance or completion of continuing education by securing authorized signatures, ~~*or other*~~ documentation, or electronic verification from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be maintained by the licensee and provided upon request by the Board or its agent. ~~*(3-20-04)*~~( )

08. Excess Hours. Continuing education hours, not to exceed six (6) hours, accumulated during the twelve (12) months immediately preceding a license renewal may be applied toward meeting the continuing education requirement for the following license renewal. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) year. (3-30-07)

301. -- 324. (RESERVED)

325. CODE OF ETHICS (RULE 325).

01. Patient's Visual Welfare. The licensed optometrist shall keep the patient's visual welfare uppermost in his consideration at all times and promote the best methods of care for the visual needs of mankind. (7-1-93)

02. Confidentiality. The optometrist shall preserve information concerning his patients in confidence and not release that information unless authorized by the patient or their lawful agent. An optometrist may, however, supply information of an otherwise confidential or privileged nature when lawfully subpoenaed to testify at a deposition or hearing in any proceeding before the Board of Optometry, or at any other time and place ordered by a court of law. ~~*(7-1-93)*~~( )

03. Conduct of Practice. The optometrist shall conduct his practice in a dignified and professional manner and in keeping with the mode of practice of a professional person entrusted with the care of the health of citizens of this state and shall abide by the rulings of the Board of Optometry. (7-1-93)

04. Unprofessional Conduct. In order to define what constitutes unprofessional conduct, the board sets forth certain prohibited actions. In conducting his practice, an optometrist must not: (3-30-07)

a. Practice optometry in any manner other than as a professional person in an individual capacity, or in partnership with or associate with other licensed health care professionals. An optometrist may be a stock holder in and practice as a member of a professional service corporation with other licensed health care professionals as authorized by Title 54, Chapter 15, Idaho Code, but the optometrist must list his individual name as well as any name selected for the professional service corporation on any letterheads, telephone directories, office or building directories, or other places where the general public might be advised of the fact that the individual is practicing optometry, as required by these rules. (3-30-07)

b. Use either "Cappers" or "Steerers" or accept a split or divided fee for the purpose of obtaining patients or use solicitors or agents for the purpose of securing patients or conducting eye examinations or furnishing optometric services. (7-1-93)

c. Allow his prescription files and records to be used by any unlicensed person, firm, or corporation not under the direct control of that optometrist for the practice of optometry. ~~(7-1-93)~~( )

d. Fail to perform services for which fees have been received. (7-1-93)

e. File false reports of services performed or fees rendered. (7-1-93)

f. Permit the use of his name or professional title by or in conjunction with any person not an optometrist, or any firm, company, corporation or military association which illegally practices or in any manner holds himself or itself out to the public as being entitled to practice the profession of optometry when not licensed to do so under the law of Idaho or which uses the title "Optometric Services" in such a manner in advertising as to convey to the public the impression that the individual or corporation is entitled to practice optometry or furnish optometric advice or services when not so authorized by law. (7-1-93)

~~*g. Enter into or continue in a contract, agreement, or understanding of any kind, or engage in any course of conduct with any person, firm or corporation, or their agents, whereby said optometrist expressly or impliedly agrees:* (7-1-93)~~

~~*i. To refer the patient back to said person, firm, or corporation referring the patient for any subsequent service or receipt of ophthalmic material.* (7-1-93)~~

~~*ii. That if any patient is referred by any person, firm or corporation to the optometrist, the optometrist will refrain from supplying to the patient any ophthalmic materials.*~~

~~*(7-1-93)*~~

~~***h.*** *Directly or indirectly give any person, association, firm or corporation, or their agents, anything of pecuniary benefit or value as consideration for the referral of any patient to said optometrist.*~~ ~~*(7-1-93)*~~

326. -- 424. (RESERVED)

425. RULES DEFINING GROSS INCOMPETENCE (RULE 425).
In order to protect the public, the Board of Optometry defines as "gross incompetence" any behavior or practice on the part of the licensed optometrist which demonstrates a lack of competence with respect to discharging professional obligations or duties which might result in injury or damage to a patient whether such injury or damage actually occurs or not and in particular, the Board defines as "gross incompetence" any of the following: (11-6-93)

01. Failure to Meet Prevailing Standards. Failure to meet prevailing standards, or willful rendering of substandard care, either individually or as part of a third party reimbursement agreement or by other agreement. (7-1-97)

02. Failure to Meet Prevailing Standards in the Referral of Any Patient Who Is Suffering From Any Apparent or Suspected Pathological Condition. A failure to meet prevailing standards in the referral of any patient who is suffering from any apparent or suspected pathological condition to a person competent and licensed to properly treat or diagnose the condition. (7-1-93)

03. Employment of Techniques or Methods of Practice. Employment of techniques or methods of practice in treating or prescribing for a patient when he does not have proper training in the technique or methods of practice. (7-1-93)

04. Failure to Advise Patient of Possible Danger When a Lens Not Meeting Impact Resistance Standards of F.D.A. Failure to advise his patient of possible danger when a lens does not meet~~*ing*~~ impact resistance standards of F.D.A. Regulation, ~~*Sec. 3.84,*~~21 CFR 801.410, and is provided ~~*for*~~ to the patient. ~~*(7-1-93)*~~( )

05. Failure to Provide Follow-Up Care. Failure to provide follow-up care according to prevailing standards. (11-6-93)

06. Displaying Gross Ignorance or Demonstrating Gross Inefficiency. Displaying gross ignorance or demonstrating gross inefficiency in the care of a patient. (7-1-93)

07. Failure to Verify the Specifications of All Lenses. Failure to verify the specifications of all lenses provided by him. (11-6-93)

08. Failing to Perform Tests and Record Findings. In the course of an examination of a patient, failure to perform tests and record findings in a manner consistent with prevailing standards of optometric care. (11-6-93)

09. Using Pharmaceutical Agents. Using pharmaceutical agents in the practice of optometry without having attended sufficient training programs or schools and acquiring the knowledge necessary to use the drugs in a competent manner. (11-6-93)

10. Illegal Prescription Sale, Administration, Distribution, or Use of Drugs. Prescribing, selling, administering, distributing, giving, or using drugs legally classified. Prescribing, selling, administering, distributing, giving, or using drugs legally classified as a controlled substance or as an addictive or dangerous drug for other than accepted diagnostic or therapeutic purposes. (7-1-97)

11. Disciplinary Action or Sanctions. Disciplinary action or sanctions taken by another state, jurisdiction, peer review body or a professional association or society against an optometrist for acts or conduct similar to acts or conduct which would constitute grounds for action as defined under "Rules of the Idaho Board of Optometry." (7-1-97)

12. Sanitary Office. ~~*Has failed*~~ Failure to maintain sanitary office conditions, equipment, and use appropriate techniques and procedures. ~~*(7-1-97)*~~( )

13. Failure to Release Prescription. Failure to release either a spectacle or contact lens prescription as required by Federal law. (3-29-10)

14. Sufficient Training or Education. Performing procedures without having successfully completed education, instruction or certification. ( )

426. -- 449. (RESERVED)

450. ~~*CONTENTS OF*~~ PRESCRIPTIONS FOR SPECTACLES AND CONTACT LENSES (RULE 450).
Eyeglasses and contact lenses, including plano or cosmetic contact lenses, may only be dispensed upon a current prescription issued by an optometrist or medical physician. Every prescription written or issued by an optometrist practicing in Idaho shall contain at least the following information: ~~*(7-1-93)*~~( )

01. Prescription for Spectacles. Prescriptions for spectacles must contain the following: (7-1-93)

a. Sphere, cylinder, axis, prism power and additional power, if applicable; and (3-30-07)

b. The standard expiration date of the prescription must be at least one (1) year from date the prescription was originally issued. (3-29-10)

02. All Prescriptions for Rigid Contact Lenses. All prescriptions for rigid contact lenses must contain at least the following information: (7-1-93)

a. Base curve; (7-1-93)

b. ~~*Peripheral curve or curves including width*~~ Lens manufacturer or "brand" name;

~~(7-1-93)~~( )

c. Overall diameter; (7-1-93)

d. ~~Optical zone diameter~~ Lens material; ~~(7-1-93)~~( )

e. Power; and (3-30-07)

f. The standard expiration date of the prescription must be at least one (1) year from date the prescription was originally issued. A shorter prescription period may be allowed when based upon a documented medical condition. (3-29-10)

03. All Prescriptions for Soft Contact Lenses. All prescriptions for soft contact lenses must contain at least the following information: (7-1-93)

a. Lens manufacturer or "brand" name; (7-1-93)

b. Series or base curve; (7-1-93)

c. Power; (7-1-93)

d. Diameter, if applicable; (7-1-93)

e. Color, if applicable; and (7-1-93)

f. The standard expiration date of the prescription is one (1) year from date the prescription was originally issued. A shorter prescription period may be allowed when based upon a documented medical condition. (3-29-10)

04. Alteration of Prescriptions. A person may not alter the specifications of an ophthalmic lens prescription without the prescribing doctor's consent. ( )

05. Expired Contact Lens Prescription. A person may not fill an expired contact lens prescription. ( )

06. Fitting and Dispensing Contact Lenses. ( )

a. Contact lenses may be fitted only by an optometrist, or licensed physician. ( )

b. An ophthalmic dispenser may dispense contact lenses on a fully written contact lens prescription issued by an optometrist or licensed physician. ( )

c. Notwithstanding Subsection 450.05.b., an optometrist, or licensed physician who issues a contact lens prescription remains professionally responsible to the patient. ( )

451. -- 474. (RESERVED)

475. PATIENTS RECORDS (RULE 475).

01. Optometrist Shall Keep a Complete Record of All Patients Examined. Every optometrist practicing in the state of Idaho shall keep a complete record of all patients examined by him or for whom he has adapted optical accessories, including copies of prescriptions issued to the patient and copies of statements of charges delivered or provided to the patient. All such records shall be maintained in an orderly and accessible manner and place and shall be maintained for at least five (5) years following the optometrist's last professional contact with the patient. Failure to maintain such records is deemed to be unprofessional conduct and constitutes gross incompetence in the handling of the patient's affairs. (7-1-93)

02. Prescription Files. The prescription files and all records pertaining to the practice of optometry shall be maintained as the sole property of the optometrist and not be distributed to any unlicensed person except as required by law or when lawfully subpoenaed in a criminal or civil proceeding in court, or subpoenaed for presentation at a deposition or hearing authorized by the Board of Optometry. (7-1-93)

03. Storage of Patient Records. Storage of patient records must be in compliance with rules in accordance with Health Insurance Portability and Accountability Act (HIPAA) including that patient records must be stored in an area inaccessible to patients. ( )

(BREAK IN CONTINUITY OF SECTIONS)

575. FEES (RULE 575).

01. Annual Renewal Fee. Annual renewal fee for license - seventy-five dollars ($75). (7-1-97)

02. Annual ~~Optometry~~ Fund Fee. Annual ~~optometry~~ fund fee - seventy-five dollars ($75). ~~(7-1-97)~~( )

03. License Application Fee. License application fee - one hundred dollars ($100). (7-1-93)

04. Certificate to Obtain and Use Pharmaceutical Agents Fee. Certificate to obtain and use pharmaceutical agents fee - ten dollars ($10). (3-30-01)

576. -- 599. (RESERVED)

600. BOARD CERTIFICATION OF OPTOMETRIST AUTHORIZED TO OBTAIN AND USE PHARMACEUTICAL AGENTS (RULE 600).

01. The Right to Obtain and Use Topically Applied Diagnostic Pharmaceutical Agents. The right to obtain and use topically applied diagnostic pharmaceutical agents for use in diagnosis of another in the practice of optometry as defined by Section 54-1501, Idaho Code, is

subject to the following conditions set out below: (7-1-93)

a. Optometrists who have obtained a certificate from the Board of Optometry authorizing them to obtain and use topically applied diagnostic pharmaceutical agents shall obtain, from pharmacists licensed by the state of Idaho, or from any other source, and use only those agents listed below: (7-1-93)

i. ~~*Anesthetics:*~~ All medications for use in the diagnosis of conditions of the human eye and/or eyelid. ~~*(7-1-93)*~~( )

~~*(1) Proparacaine 0.5%;* (7-1-93)~~

~~*(2) Tetracaine 0.5%;* (7-1-93)~~

~~*(3) Benoxinate 0.4% c fluorescein.* (7-1-93)~~

ii. ~~*Cycloplegics:*~~ All over-the-counter agents. ~~*(7-1-93)*~~( )

~~*(1) Tropicamide 0.5%;* (7-1-93)~~

~~*(2) Cyclopentolate 0.5%;* (7-1-93)~~

~~*(3) Atropine 0.5%.* (7-1-93)~~

iii. ~~*Mydriasis Reversal Agents:*~~ Such other diagnostic pharmaceutical agents as may be approved by the Board of Optometry. ~~*(7-1-93)*~~( )

~~*(1) Dapiprazole HCl 0.5%.* (7-1-93)~~

b. The Board of Optometry shall issue a certificate to obtain and use the diagnostic drugs specifically identified and listed in this rule to any optometrist licensed to practice in Idaho who complies with both the minimum educational requirements in the subject of general and ocular pharmacology and the minimum continuing educational requirements set out below:. (7-1-93)

i. Each optometrist certified to obtain and use topically applied pharmaceutical agents shall have completed courses totaling fifty-five (55) hours of actual classroom instruction in general and ocular pharmacology and emergency medical care given by an institution approved by the Council on Post Secondary Accreditation of the U.S. Department of Education or an instructor accredited and employed by such institution and which have been approved by the Board of Optometry. (7-1-93)

ii. Each optometrist certified to obtain and use topically applied pharmaceutical agents shall also have completed a refresher course in cardiopulmonary resuscitation (CPR), emergency medical care provided by the Emergency Medical Services Bureau, or equivalent program either approved or provided by the Board of Optometry, within a two (2) year period preceding issuance of the certificate by the Board of Optometry. (7-1-93)

iii. In order to maintain the certificate issued by the Board, each certified optometrist must complete a refresher course in ~~*emergency medical care*~~ CPR described in Subsection 600.01.b.ii. above once during each two (2) year period following certification and shall list and describe the course attended and the dates of attendance upon a license renewal application form filed pursuant to Section 300. ~~*(7-1-93)*~~( )

c. In order to implement this rule, the Board of Optometry may designate and approve courses of instruction given by those institutions or instructors described in Subsection 600.01.b.i. above which may be necessary to provide practicing optometrists who have received less than fifty-five (55) hours of actual classroom instruction in general and ocular pharmacology in optometry school with the opportunity to meet the requirements of this rule. (7-1-93)

02. The Right to Prescribe, Administer and Dispense Therapeutic Pharmaceutical Agents. The right to prescribe, administer and dispense therapeutic pharmaceutical agents in the practice of optometry as defined by Section 54-1501, Idaho Code, is subject to the following conditions set out below: (11-6-93)

a. Optometrists who have obtained a certificate from the Board of Optometry authorizing them to prescribe, administer and dispense therapeutic pharmaceutical agents shall obtain, from pharmacists licensed by the State of Idaho, or from any other source, and use only those agents listed below: (11-6-93)

i. All medications for use in the treatment of the human eye and/or eyelid. (7-1-97)

ii. All over-the-counter agents. (11-6-93)

iii. Such other therapeutic pharmaceutical agents as may be approved by the Board of Optometry. (11-6-93)

b. The Board of Optometry shall issue a certificate to prescribe, administer and dispense the therapeutic medications to any optometrist licensed to practice in Idaho who complies with Subsection 600.01 and both the minimum educational and clinical experience requirements in the subject of ocular pharmacology and therapeutics and the minimum continuing educational requirements set out below: (7-1-97)

i. Completion of a minimum of one hundred (100) hours of actual classroom and clinical instruction in ocular pharmacology and therapeutics courses given by an institution or organization approved by the Council on Post-Secondary Accreditation of the U.S. Department of Education, or an Instructor employed by such institution, which have been approved by the Board of Optometry. (7-1-93)

ii. Successful passage of the "Treatment and Management of Ocular Diseases" section of the optometrist examination approved by the Association of Regulatory Boards of Optometry, Inc. (ARBO) or its equivalent as approved by the Board. ~~*(3-30-01)*~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.12.01 - RULES OF THE IDAHO STATE BOARD OF PSYCHOLOGIST EXAMINERS

DOCKET NO. 24-1201-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2305, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 566 through 568**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-2305, 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 October 17, 2012.

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 State Board of Psychologist Examiners is updating this rule to clarify continuing education obtained through workshops, classes, training experiences, and teleconferences and to set the number of continuing hours allowed.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no fiscal impact to general or dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rule is simple in nature and was discussed at a noticed meeting open to the public.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1201-1201

402. GUIDELINES FOR APPROVAL OF CONTINUING EDUCATION CREDITS (RULE 402).

01. Continuing Education Credit. Continuing education credit will be given to formally organized workshops or classes with an attendance roster and preassigned continuing education credit offered in association with or under the auspices of: (7-1-93)

a. Regionally accredited institutions of higher education. (7-1-93)

b. The American Psychological Association. (7-1-93)

c. A Regional Psychological Association. (7-1-93)

d. A State Psychological Association. (7-1-93)

e. Credit will be given for the number of credit hours preauthorized by the sponsoring agency with no upper limit on the number of hours. (7-1-93)

02. Credit for International, National and Regional Meetings of Psychological Organizations. Six (6) hours of continuing education credit will be allowed for documented attendance at international, national and regional meetings of psychological organizations. (7-1-93)

03. Credit for Other Relevant Workshops, Classes or Training Experiences. Other relevant workshops, classes or training experiences when not offered, approved, or provided by an entity in Subsection 402.01, may receive up to six (6) hours of credit per experience provided they are conducted by a licensed or reputable psychologist or other mental health professional. Each documented hour of training experience counts as one (1) hour of continuing education experience. ~~*A maximum of six (6) hours of this type of experience may be approved.*~~

~~*(7-1-93)*~~( )

04. Presentation of Papers. Presentation of papers at international, national, regional or state psychological or other professional associations may be counted as equivalent to six (6) hours per event. Only actual presentation time may be counted; preparation time does not qualify for credit. The licensee must provide the Board with a letter from a sponsor, host organization, or professional colleague, copy of the program, and a summary of the evaluations from the event. (3-29-10)

05. Self-Study, Lectures or Public or Professional Publications and Presentations. The Board also recognizes the value of self-study, lectures or public or professional publications and presentations (including for example, in the case of the university faculty, preparation of a new course). Therefore, the Board will allow credit for six (6) hours of individual study per year.

(7-1-93)

a. Self-Study. The reading of a publication may qualify for credit with proper documentation verifying completion. A licensee seeking credit for reading a publication must submit results from a test on the information contained within the publication. If a test is not available, the licensee must seek pre-approval of the Board. (3-29-10)

b. Professional publications. Publication activities are limited to articles in professional journals, a chapter in an edited book, or a published book. The licensee must provide the Board with a copy of the cover page of the article or book in which the licensee has been published. For chapters of an edited book, licensees must submit a copy of the table of contents. (3-29-10)

06. Board Assessment of Continuing Education Activities. The Board of Psychologist Examiners may avail itself of help and consultation from the American Psychological Association or the Idaho Psychological Association in assessing the appropriateness of continuing education activities. (3-29-10)

07. On-Line Education. A maximum of ten (10) on-line continuing education hours relevant to the practice of psychology may be counted during each reporting period. (3-29-10)

a. On-line continuing education hours must be offered by or obtained from regionally accredited institutions of higher education or approved by the American Psychological Association. (3-29-10)

b. The licensee must provide the Board with a copy of the certification, verified by the authorized signatures from the course instructors, providers, or sponsoring institution, substantiating any hours completed by the licensee. (3-29-10)

08. Teleconferences. ~~*A maximum of six (6) continuing education hours may be counted through teleconference education during each reporting period.*~~ To qualify for credit, teleconferences must feature an interactive format. Interactive conferences are those that provide the opportunity for participants to communicate directly with the instructor or that have a facilitator present at the conference site. The licensee must provide the Board with a copy of the certificate, or a letter signed by course instructors, providers, or sponsoring institution, substantiating any hours attended by licensee. ~~*(3-29-10)*~~( )

a. When offered, approved, or provided by entities in Subsection 402.01, the number of hours that may be counted during each reporting period is not limited. ( )

b. When not offered, approved, or provided by an entity in Subsection 402.01, a maximum of six (6) hours may be counted during each reporting period. ( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.14.01 - RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3204, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed with the exception of two changes to the new section 210. Based on comment received, the Board has amended 210.02.b. and 210.03.b. to allow the Board to extend the time frame to obtain supervised work experience beyond five (5) years if good cause is shown.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 569 through 579.**

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3204, 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 October 17, 2012.

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 Board of Social Work Examiners is changing its rules to clarify the definition of a relative for purposes of the code of conduct. The proposed rule changes clarify independent practice, and supervision requirements through the creation of a new supervision section. The rule changes require renewal of a Supervisor registration, clarify inactive licenses, and update the examination process. Finally, changes are needed to the code of professional conduct to clarify appropriate relationships between a licensee and client.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rules were discussed during scheduled, noticed board meetings.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1401-1201

010. DEFINITIONS (RULE 10).

01. Board. The State Board of Social Work Examiners as prescribed in Section 54-3202, Idaho Code. (7-1-93)

02. Bureau. The Bureau means the Bureau of Occupational Licenses, as prescribed in Sections 54-3204 and 67-2602, Idaho Code. (3-13-02)

03. Psychotherapy. Treatment methods using a specialized, formal interaction between a Clinical Social Worker and an individual, couple, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, intrapersonal, interpersonal, and psychosocial dynamics, and the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. (3-20-04)

04. Relative. For the purposes of these rules, a relative is a person's spouse, parent, child, or sibling, regardless of whether the relation is by blood, through marriage, or by law. ( )

045. Supportive Counseling. Supportive counseling by a social worker means a method used by social workers to assist individuals, couples, families, and groups in learning how to solve problems and make decisions about personal, health, social, educational, vocational, financial, and other interpersonal concerns. This help in the maintenance of adaptive patterns is done in the interview through reassurance, advice giving, information providing, and pointing out client strengths and resources. Supportive counseling does not seek to reach unconscious material. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

201. PRACTICE OF SOCIAL WORK (RULE 201).

01. Baccalaureate Social Work. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a

generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. Baccalaureate social work can include independent practice, but not private practice. ~~(3-20-04)~~( )

02. Master's Social Work. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist and in accordance with an approved supervision plan. Master's social work can include independent practice, but not private practice. ~~(3-20-04)~~( )

03. Clinical Social Work. The practice of clinical social work is a specialty within the practice of master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work includes, but is not limited to, individual, couples, family and group psychotherapy, and includes independent and private practice. (3-20-04)

04. Independent Practice of Social Work. As defined in Section 54-3207, Idaho Code, independent practice is that practice in which an individual who, wholly or in part, practices social work autonomously with total responsibility for such independent practice.( )

0~~4~~5. Private Practice of Social Work. As defined in Section 54-3207, Idaho Code, is that independent practice in which an individual sets up and maintains responsibility for the contractual conditions of payment with clients, agencies, or institutions. (5-3-03)

0~~5~~6. Employment of a Social Worker. A social worker employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility, is not to be considered within the definition of an independent practitioner. Furthermore, a social worker who contracts with an agency or institution that assumes full responsibility for and supervises the services provided to clients is not considered to be a private practitioner. (5-3-03)

~~***06. Supervision**. Supervised experience shall be required for both independent practice status and clinical licensure. Consultative-teaching supervision is directed toward*~~

~~*enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. A total of three thousand (3,000) hours of supervised social work experience accumulated in not less than two (2) years is required. Actual supervisor contact shall be face-to-face and provided by a qualified and experienced professional working in the same area of practice and must occur on a regular and on-going basis and consist of a minimum of one hundred hours (100) hours. Ratio of supervisor/supervisee shall not exceed two (2) social workers to one (1) supervisor per hour of supervision. Group supervision totaling no more than fifty (50) hours will be allowed for groups of no more than six (6) persons and the allowable credit shall be prorated at the two to one (2 to 1) ratio (total session minutes divided by total supervisees multiplied by two (2) equals maximum allowable credit per supervisee for the session. i.e. an individual attending a one (1) hour group supervisory session consisting of six (6) supervisees shall be allowed twenty (20) minutes of group supervision credit). Supervisors must hold a degree in social work and a current license in good standing, except as noted in Subsection 201.06.c.*~~
~~*(4-2-08)*~~

~~***a.*** *Supervision of baccalaureate social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the baccalaureate, masters, or clinical level.* *(3-20-04)*~~

~~***b.*** *Supervision of masters social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the masters or clinical level.* *(5-3-03)*~~

~~***c.*** *Supervision of master level social workers pursuing licensure as clinical level practitioners must be provided by either a licensed clinical social worker who is registered as a supervisor, a licensed clinical psychologist, a person licensed to practice medicine and surgery who practices in the area of psychiatry, a licensed clinical professional counselor registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists or a licensed marriage and family therapist registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists and must focus on clinical social work as defined. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker registered as a supervisor. A master level social worker pursuing licensure at the clinical level must document three thousand (3000) hours of supervised practice as follows:* *(4-7-11)*~~

~~*i.* *One thousand seven hundred fifty (1,750) hours of direct client contact involving treatment in clinical social work as defined; and* *(4-7-11)*~~

~~*ii.* *One thousand two hundred fifty (1,250) hours involving assessment, diagnosis, and other clinical social work as defined.* *(4-7-11)*~~

~~***d.*** *Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision.* *(3-20-04)*~~

~~***07. Supervised Practice Required****. To be eligible for licensure as an independent practitioner a candidate must:* *(5-3-03)*~~

~~***a.*** *Meet the requirements set forth in Subsection 201.06;* *(4-2-08)*~~

~~***b.*** *Develop a plan for supervision that must be approved by the Board prior to commencement of supervision. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by the Board prior to the commencement of supervision by the new supervisor; and* *(5-3-03)*~~

~~***c.*** *Not have more than two (2) supervisors at any given time.* *(5-3-03)*~~

~~***08. Out of State Supervised Experience***. *The Board may consider supervised experience obtained outside the state of Idaho submitted for Idaho license purposes. Supervised experience must be provided by a licensed clinical social worker, licensed marriage and family therapist, licensed clinical psychologist, or a person licensed to practice medicine and surgery who practices in the area of psychiatry. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker. The applicant must meet the other requirements of supervised practice as set forth in these rules.* *(4-2-08)*~~

202. -- 209. (RESERVED)

210. SUPERVISION (RULE 210).

01. Generally Applicable Supervision Requirements. All supervised experience, as set forth in this section, must meet the following requirements: ( )

a. Supervision must be consultative-teaching supervision which is directed toward enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. ( )

b. A minimum of one hundred (100) hours of the required supervision must be face-to-face contact with the supervisor and must occur on a regular and on-going basis. ( )

i. A supervisee may count in full all time in a supervisory session where the ratio of supervisor to supervisees does not exceed one (1) supervisor to two (2) social workers. All one hundred (100) hours may be earned in such a one (1) to two (2) setting. ( )

ii. Group supervision may count for no more than fifty (50) hours of face-to-face contact. Group supervision may count only where the ratio of supervisor to supervisees does not exceed one (1) supervisor to six (6) supervisees, and the allowable countable time shall be prorated by the following formula: total session minutes divided by total supervisees, multiplied by two (2) equals the maximum allowable countable time per supervisee for the session. i.e. a supervisee attending a one (1) hour group supervisory session consisting of six (6) supervisees shall be allowed twenty (20) minutes of group supervision credit (60 minutes/6 supervisees x 2 = 20 minutes). ( )

02. Pursuing Licensure As Independent Practitioners. Requirements for supervision of baccalaureate or master's social workers pursuing licensure as independent practitioners. ( )

a. Develop a plan for supervision that must be reviewed and approved by a designated Board member prior to commencement of supervision. ( )

b. Complete a minimum of three thousand (3,000) hours of supervised social work experience. *The hours shall be* accumulated in not less than two (2) years but in not more than five (5) years *unless an extension is approved by the Board for good cause shown*. ( )

c. Supervision must be provided by a qualified and experienced licensed social worker with a current license in good standing and approved to pursue independent practice. ( )

i. For a baccalaureate social worker the supervisor must hold a license at the baccalaureate, masters, or clinical level. ( )

ii. For a masters social worker the supervisor must hold a license at the masters, or clinical level. ( )

iii. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by a designated member of the Board prior to the commencement of supervision by the new supervisor. ( )

iv. The supervisee may not have more than two (2) supervisors at any given time. ( )

03. Pursuing Licensure As Clinical Social Worker. Requirements for supervision of master's social workers pursuing licensure as clinical social worker. ( )

a. Develop a plan for supervision that must be reviewed and approved by a designated Board member prior to commencement of supervision. ( )

b. Complete a minimum of three thousand (3,000) hours of supervised social work experience focused on clinical social work. *The hours shall be* accumulated in not less than two (2) years but in not more than five (5) years *unless an extension is approved by the Board for good cause shown. The hours shall also meet the following:* ( )

i. One thousand seven hundred fifty (1,750) hours of direct client contact involving treatment in clinical social work as defined; and ( )

ii. One thousand two hundred fifty (1,250) hours involving assessment, diagnosis, and other clinical social work as defined. ( )

c. Fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker registered as a supervisor pursuant to Section 211 of these rules. The remaining fifty percent (50%) of supervision may be provided by one or more of the following: ( )

i. A licensed clinical social worker who is registered as a supervisor pursuant to

Section 211; ( )

ii. A licensed clinical psychologist; ( )

iii. A person licensed to practice medicine and surgery who practices in the area of psychiatry; ( )

iv. A licensed clinical professional counselor registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists; or ( )

v. A licensed marriage and family therapist registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists. ( )

d. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by a designated member of the Board prior to the commencement of supervision by the new supervisor. ( )

e. The supervisee may not have more than two (2) supervisors at any given time. ( )

04. Out-of-State Supervised Experience. The Board may consider supervised experience obtained outside the state of Idaho submitted for Idaho licensure purposes. Such experience, whether already obtained or planned to be obtained, must be included in the plan for supervision and reviewed and approved by a designated Board member. ( )

a. Supervised experience must be provided by one or more of the following: ( )

i. A licensed clinical social worker; ( )

ii. A licensed clinical professional counselor; ( )

iii. A licensed marriage and family therapist; ( )

iv. A licensed clinical psychologist; or ( )

v. A person licensed to practice medicine and surgery who practices in the area of psychiatry. ( )

b. Supervised experience provided by an individual other than a licensed clinical social worker may only satisfy a maximum of fifty percent (50%) of the required hours. ( )

c. Previous supervised experience must have been obtained within the five year period preceding the submission of the plan for supervision and must have been obtained in compliance with the law and rules of the state in which the experience was obtained. ( )

d. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by a designated member of the Board prior to the commencement of supervision by the new supervisor. ( )

e. The applicant must meet the other requirements of supervised practice as set forth in these rules. ( )

2~~02~~11. SOCIAL WORK SUPERVISOR REGISTRATION (RULE 2~~02~~11).
~~*Effective January 1, 2007,*~~ Idaho licensed social workers shall be registered with the Board in order to provide postgraduate supervision for those individuals pursuing licensure in Idaho as a clinical social worker. ~~*(4-11-06)*~~( )

01. Requirements for Registration. (3-14-05)

a. Document at least two (2) years experience as an Idaho licensed clinical social worker. ~~*(4-11-06)*~~( )

b. Have not been the subject of any disciplinary action for five (5) years prior to application for registration. (3-14-05)

c. Document fifteen (15) contact hours of education in clinical supervisor training as approved by the Board, or if previously registered as a supervisor with the Board, document six (6) hours of education in advanced supervisor training as approved by the Board. ~~*(4-2-08)*~~( )

02. Registration. A supervisor applicant shall submit to the Bureau a completed application form as approved by the board. (3-14-05)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. (3-14-05)

b. A supervisor's registration shall ~~*be*~~ remain valid only so long as the individual's clinical social worker license remains current and in good standing. ~~*(3-14-05)*~~( )

03. Renewal. Subject to the conditions in Paragraph 211.03.c., a supervisor's registration is valid for a term of five (5) years. To renew a supervisor registration, the registered supervisor must submit to the Board a complete application for registration renewal on forms approved by the Board and meet the following requirements: ( )

a. Hold an active Idaho clinical social worker license which has not been subject to discipline and is current and in good standing; and ( )

b. Document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous five (5) years. ( )

c. For supervisors registered prior to the effective date of this rule subsection 211.03.,the following renewal requirements and conditions apply: ( )

i. A registered supervisor who has been registered for at least five (5) years prior to July 1, 2013 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2015. ( )

ii. A registered supervisor who has been registered for less than five (5) years prior to July 1, 2013 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2017. ( )

2~~03~~12. -- 224. (RESERVED)

225. INACTIVE STATUS (RULE 225).

01. Request for Inactive Status. Each person requesting an inactive status ~~*during the renewal of their active license*~~ must submit a written request and pay the ~~*established*~~ inactive license fee. ~~*(4-9-09)*~~( )

02. Inactive License Status. (4-9-09)

a. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho (4-9-09)

b. Inactive license renewal notices and licenses will be marked "Inactive." (4-9-09)

c. When the licensee desires active status, he must show acceptable fulfillment of continuing education requirements for the previous twelve (12) months and submit a fee equivalent to the difference between the inactive and active renewal fee. (4-9-09)

d. Licensees shall not practice in Idaho while on inactive status. (4-9-09)

(BREAK IN CONTINUITY OF SECTIONS)

350. EXAMINATIONS, ENDORSEMENT, AND BOARD MEETINGS (RULE 350).
~~*Examinations will be conducted by the board for qualified applicants for social work licensing and board meetings will be held to conduct other business.*~~ Applications for examination may be reviewed and approved by a designated Board member upon determination that the applicant meets the qualifications for examination. Approval to sit for examination does not obligate the Board to issue a license if it is later determined that the applicant does not meet the requirements for licensure. ~~*(3-20-04)*~~( )

01. Board Meetings. Board meetings will be held at least three (3) times each year at such times and places as the board deems necessary. (5-3-03)

02. Exam ~~*Utilized*~~. The Board ~~*utilizes*~~ approves the uniform, nationally standardized examination of the Association of Social Work Boards (ASWB) as the Idaho licensure examination. ~~*(5-3-03)*~~( )

a. Bachelor level candidates shall be required to successfully pass the bachelor's

examination. (4-2-08)

b. Masters level candidates shall be required to successfully pass the master's examination. (4-2-08)

c. Clinical level candidates shall be required to successfully pass the clinical examination. (5-3-03)

03. Dates of Exams. Examination at all levels of social work licensing will be conducted on dates established for national administration. (7-1-93)

04. Graduation Date to Qualify for Exam. Candidates for examination who can satisfy the board that they will be graduating at the end of the spring, summer or fall terms of any given year, may qualify for examination ~~*at the established testing period*~~ immediately preceding the date of graduation. ~~*(5-24-95)*~~( )

~~***05. Exemption from Exam.*** *An applicant who has been tested for licensure utilizing an acceptable examination will be exempt from the Idaho examination if the applicant received a converted score of seventy (70) based upon a criterion reference examination.* *(7-1-93)*~~

0~~6~~5. Endorsement. The Board may grant a license to any person who submits a completed application on a form approved by the Board together with the required fees and who: (5-3-03)

a. Holds a current, active social work license, at the level for which a license is being sought, issued by the authorized regulatory entity in another state or country, the certification of which must be received directly by the Board from the issuing agency; and (3-20-04)

b. Has not been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily surrendered a license; and (5-3-03)

c. Is of good moral character and has not been convicted, found guilty, or received a withheld judgment or suspended sentence for any felony; and (5-3-03)

d. Has successfully passed an examination, as referenced in Subsection 350.02, or an examination provided by the Professional Examination Service (PES) at the clinical social worker and social worker level or the Education Testing Service (ETS) examination; and (5-3-03)

e. Has certified under oath to abide by the laws and rules governing the practice of social work in Idaho and the code of professional conduct. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

450. STATEMENT OF PUBLIC POLICY AND CODE OF PROFESSIONAL CONDUCT (RULE 450).
The profession of social work is dedicated to serving people; the professional relationship between social workers and clients thus shall be governed by the highest moral and ethical values. The client is in a vulnerable role that extends beyond the time frame of actual services. In both social and professional interactions, this vulnerability shall be taken into consideration whether the person is currently or has been a client. Following is the Code of Professional Conduct: (5-24-95)

01. The Social Worker's Ethical Responsibility to Clients. (7-1-93)

a. For the purpose of this Code of Professional Conduct, a client is anyone for whom the social worker provides social work services directly or indirectly through consultations, staffings, or supervision with other professionals. (7-1-93)

b. The social worker shall not commit fraud nor misrepresent services performed. (7-1-93)

c. The social worker shall not solicit the clients of an agency for which they provide services for his private practice. (7-1-93)

d. The social worker shall not divide a fee or accept or give anything of value for receiving or making a referral. (7-1-93)

e. The social worker shall provide clients with accurate and complete information regarding the extent and nature of the services available to them. (7-1-93)

f. The social worker shall terminate service to clients, and professional relationships with them, when such service and relationships are no longer required or in which a conflict of interest arises. (7-1-93)

g. A social worker shall not violate a position of trust by knowingly committing any act detrimental to a client. (7-1-93)

h. A social worker shall not exploit their professional relationships with clients (or former clients), supervisees, supervisors, students, employees, or research participants, sexually or otherwise. Social workers shall not condone or engage in sexual harassment. Sexual harassment is defined as deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are unwelcomed by the recipient. (7-1-93)

i. A social worker shall not engage in romantic or sexual acts with a client or with a person who has been a client within the past three (3) years, with a relative of a client, or with a person with whom the client maintains a close personal relationship when it has the potential to be harmful to the client. A social worker shall not provide social work services to a person with whom he/she has had a romantic or sexual relationship. ~~(7-1-93)~~( )

02. The Social Worker's Conduct and Comportment as a Social Worker. (7-1-93)

a. In providing services, a social worker shall not discriminate on the basis of age, gender, race, color, religion, national origin, mental status, physical disability, social or economic status, political belief, or any other preference or personal characteristic, condition or status. (4-2-08)

b. Social workers shall not undertake any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student, or research participant. If engaged in such activity when they become aware of their personal problems, they shall seek competent professional assistance to determine whether they should suspend, terminate, or limit the scope of their professional activities. (7-1-93)

c. A social worker shall not practice while impaired by medication, alcohol, drugs, or other chemicals. A social worker shall not practice under a mental or physical condition that impairs the ability to practice safely. (4-2-08)

d. A social worker shall not repeatedly fail to keep scheduled appointments. (7-1-93)

e. The social worker who anticipates the termination or interruption of service to clients shall notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences. (7-1-93)

f. The social worker shall attempt to make appropriate referrals as indicated by the client's need for services. (7-1-93)

g. A social worker shall obtain the client's or legal guardian's informed written consent when a client is to be involved in any research project. A social worker shall explain the research, including any implications. (7-1-93)

h. The social worker shall obtain informed consent of clients before taping, recording, or permitting third party observation of their activities. (7-1-93)

i. A social worker shall safeguard information given by clients in providing client services. Except when required by law or judicial order, a social worker shall obtain the client's informed written consent before releasing confidential information from the setting or facility except for compelling reasons defined as but not limited to: (7-1-93)

i. Consultation with another professional on behalf of the client thought to be dangerous to self or others; (7-1-93)

ii. Duty to warn pursuant to Chapter 19, Title 6, Idaho Code; (5-24-95)

iii. Child abuse and sexual molestation pursuant to Chapter 16, Title 16, Idaho Code; and (5-24-95)

iv. Any other situation in accordance with statutory requirements. (7-1-93)

j. A social worker shall report any violation of the law or rules, including Code of Professional Conduct, by a person certified under Chapter 32, Title 54, Idaho Code. (7-1-93)

03. Competent Practice for Social Workers. All social workers shall practice in a competent manner consistent with their level of education, training and experience. (3-20-04)

a. A social worker shall only represent himself and practice within the boundaries of his education, training, licensure level, supervision, and other relevant professional experience. (3-20-04)

b. A social worker shall only practice within new areas or use new intervention techniques or approaches after engaging in appropriate study, training, consultation, or supervision. (3-20-04)

c. A social worker shall exercise careful judgment, when generally recognized standards do not exist with respect to an emerging area of practice, and take responsible steps to ensure the competence of his practice. (3-20-04)

04. The Advertising Rules for Social Workers. No social worker shall disseminate or cause the dissemination of any advertisement or advertising which is any way fraudulent, false, deceptive or misleading. Any advertisement or advertising shall be deemed by the board to be fraudulent, false, deceptive, or misleading if it: (7-1-93)

a. Contains a misrepresentation of fact; or (7-1-93)

b. Is misleading or deceptive because in its content or in the context in which it is presented it makes only a partial disclosure of relevant facts. More specifically, it is misleading and deceptive for a social worker to advertise free services or services for a specific charge when in fact the social worker is transmitting a higher charge for the advertised services to a third party payor for payment or charges the patient or a third party. It is misleading and deceptive for a social worker or a group of social workers to advertise a social work referral service or bureau unless the advertisement specifically names each of the individual social workers who are participating in the referral service or bureau. (7-1-93)

c. Creates false or unjustified expectations of beneficial treatment or successful outcomes; or (7-1-93)

d. Fails to identify conspicuously the social worker or social workers referred to in the advertising as a social worker or social workers; or (7-1-93)

e. Contains any representation or claims, as to which the social worker, referred to in the advertising, fails to perform; or (7-1-93)

f. Contains any representation which identifies the social worker practice being advertised by a name which does not include the terms “social worker,” “social work,” or some easily recognizable derivation thereof; or (7-1-93)

g. Contains any representation that the practitioner has received any license or recognition by the state of Idaho or its authorized agents, which is superior to the license and recognition granted to any social worker who successfully meets the licensing requirements of

Chapter 32, Title 54, Idaho Code; or (7-1-93)

h. Appears in any classified directory, listing, or compendium under a heading, which when considered together with the advertisement, has the capacity or tendency to be deceptive or misleading with respect to the profession or professional status of the social worker; or (7-1-93)

i. Contains any other representation, statement, or claim which is misleading or deceptive. (7-1-93)

05. Dual Relationships. A social worker shall not engage in dual or multiple relationships with clients, with relatives of a client, or with individuals with whom clients maintain close personal relationships, in which a reasonable and prudent social worker would conclude after appropriate assessment that there is a risk of harm or exploitation to the client or of impairing a social worker's objectivity or professional judgment. A dual or multiple relationship is a relationship that occurs when a social worker interacts with a client in more than one capacity, whether it be before, during, or after the professional, social, or business relationship. Dual or multiple relationships can occur simultaneously or consecutively. After an appropriate assessment that the relationship does not create a risk of harm or exploitation to the client and will not impair a social worker's objectivity or professional judgment, the social worker must document in case records, prior to the interaction, when feasible, the rationale for such a relationship, the potential benefit to the client, and anticipated consequences for the client. ( )

06. Business Relationships. A social worker shall not purchase goods or services from a client or otherwise engage in a business relationship with a client except when: ( )

a. The client is providing necessary goods or services to the general public; ( )

b. A reasonable and prudent social worker would determine that it is not practical or reasonable to obtain the goods or services from another provider; and ( )

c. A reasonable and prudent social worker would determine that engaging in the business relationship will not be detrimental to the client or the professional relationship. ( )

07. Bartering. Bartering is the acceptance of goods, services, or other nonmonetary remuneration from a client in return for a social worker's services. Social workers shall not barter except when such arrangement is not exploitative and: ( )

a. Is initiated by the client and with the client's written informed consent; and ( )

b. Has an easily determined fair market value of the goods or services received. ( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3404, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 580 through 585**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3404, 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 October 17, 2012.

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 Board of Professional Counselors and Marriage and Family Therapists is updating the Incorporation by Reference section of the rule to allow the Board to adopt the new Code of Ethics for Marriage and Family Therapists. Changes are also needed to clarify supervised experience for marriage and family therapists; and to clarify continuing education. Finally, based upon a law change last year the Board has added a rule specifying the documentation necessary for informed consent.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are simple in nature and they were discussed during noticed open meetings of the Board.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The Board is adopting the current edition of the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact

Cherie Simpson at (208)334-3233.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1501-1201

004. INCORPORATION BY REFERENCE (RULE 4).

01. ACA Code of Ethics. "ACA Code of Ethics," as published by the American Counseling Association (ACA), effective 2005 ~~*and referenced in Subsections 200, 241.02, 350, and 450.01*~~, is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(3-29-12)*~~( )

02. AAMFT Code of Ethics. The document titled "AAMFT Code of Ethics," as published by the American Association for Marriage and Family Therapy (AAMFT), effective July 1, 20~~0~~12 and referenced in Subsections 350, and 450.01, is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(3-30-06)*~~( )

03. Guidelines. The document titled "Approved Supervision Designation Handbook" that provides supervision guidelines for supervisors, as published by the American Association for Marriage and Family Therapy (AAMFT), dated October 2007 referenced in Subsection 2~~40~~39.03.a., is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(3-29-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

238. MARRIAGE AND FAMILY THERAPISTS (RULE 238).
The following requirements must be met for marriage and family therapist licensure: (3-13-02)

01. Graduate Degree. Possess a graduate degree as outlined in Section 54-3405C(1), Idaho Code. (3-13-02)

02. Practicum. Must meet the requirements as outlined in Section 54-3405C(2), Idaho Code. (3-13-02)

03. Supervised Marriage and Family Therapy Experience. Must meet the three thousand (3,000) hour requirement as outlined in Section 54-3405C(3), Idaho Code. Effective

July 1, 2004, a Idaho Marriage and Family Therapist must be registered with the Board to provide post graduate supervision for those pursuing marriage and family therapist licensure in Idaho. (3-29-12)

a. A minimum of two thousand (2,000) postgraduate direct client contact hours, in no less than a two (2) year time period shall include a minimum one thousand (1,000) direct client contact hours with couples and families; and; ~~(3-13-02)~~( )

~~i~~**b.** ~~A minimum one thousand (1,000) direct client contact hours with couples and families; and~~ Two hundred (200) hours of supervision. ~~(3-13-02)~~( )

~~ii. Two hundred (200) hours of supervision.~~ ~~(3-13-02)~~

~~b~~**c.** Effective July 1, 2014 a minimum of one hundred (100) hours post-graduate supervision must be obtained from a registered marriage and family therapist supervisor. The remaining one hundred (100) hours of supervision may also be obtained from a licensed clinical professional counselor registered as a supervisor with the Board, licensed psychologist, licensed clinical social worker registered as a supervisor with the Board of Social Work Examiners, or licensed psychiatrist who documents: (3-29-12)

i. A minimum of five (5) years of experience providing marriage and family therapy; and (3-20-04)

ii. Fifteen (15) contact hours of education in supervisor training; and (3-20-04)

iii. Has not been the subject of any disciplinary action for five (5) years immediately prior to providing supervision. (3-20-04)

~~c~~**d.** No more than one hundred (100) hours of group supervision shall be allowed. Group supervision shall be defined as up to six (6) supervisees and one (1) supervisor; and (3-29-12)

~~d~~**e.** Individual supervision is defined as up to two (2) supervisees per supervisor; and (3-13-02)

~~e~~**f.** Supervision must employ observation of client contact such as the use of audio technologies or video technologies or co-therapy, or live supervision; and (3-29-12)

~~f~~**g.** In accordance with the adopted Codes of Ethics prohibiting dual relationships, a supervisor shall not act as an applicant's personal Professional Counselor/Therapist. (3-13-02)

~~g~~**h.** The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (4-2-03)

~~h~~**i.** Supervision obtained in another state must conform with the state's requirements provided they are substantially equivalent to Idaho's requirements. (3-29-12)

04. Examination. (3-13-02)

a. The Board requires successful passage of the National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB). (3-13-02)

b. The examination will be conducted at a time and place specified by the Board. (3-13-02)

c. Successful passage of the examination is defined by the Board as achievement of the passing score set by the AMFTRB. Reexamination shall consist of the entire examination. (3-13-02)

(BREAK IN CONTINUITY OF SECTIONS)

425. CONTINUING EDUCATION (RULE 425).
Every person holding an Idaho license as a Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or a Marriage and Family Therapist must complete in each twelve-month period preceding the renewal of a license, twenty (20) contact hours of continuing education. A contact hour is one (1) hour of actual participation in a continuing education activity, exclusive of breaks. (3-29-10)

01. Contact Hours. The contact hours of continuing education must be obtained in areas of study germane to the practice for which the license is issued as approved by the Board. No less than three (3) contact hours for each renewal period must be in ethics, which must be specific to legal issues, law, or ethics. Ethics contact hours must be obtained in a face-to-face setting where you can interact with the instructor and ~~*students*~~ participants. Therapeutic workshops, retreats and other self-help activities are not considered continuing education training unless specific parts of the experience are applicable to counseling or therapy practice.
~~*(3-29-12)*~~( )

02. Documentation of Attendance. It shall be necessary for the licensee to maintain documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be provided to the Board upon request by the Board or its agent. (3-29-10)

03. Approved Contact Hours, Limitations, and Required Documents. (3-29-10)

a. College or University Courses for Credit or Audit. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. However, all courses are subject to Board approval. For college or university courses, one (1) semester credit equals fifteen (15) contact hours; one (1) quarter credit equals ten (10) contact hours. The licensee must provide the Board with a copy of the licensee's transcript substantiating any hours attended by the licensee. (3-29-10)

b. Seminars, Workshops, Conferences. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. Teleconferences must feature an interactive format in order to qualify for contact hour credit. Interactive conferences are those that provide the opportunity for participants to communicate directly with the instructor. The licensee must provide the Board with a copy of the certificate, or letter signed by course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. (3-29-10)

c. Publications. A maximum of four (4) contact hours may be counted in this category during each reporting period. Publication activities are limited to articles in journals, a chapter in an edited book, or a published book or professional publication. The licensee must provide the Board with a copy of the cover page or the article or book in which the licensee has been published. For a chapter in an edited book the licensee must submit a copy of the table of contents. (3-29-10)

d. Presentations. A maximum of four (4) contact hours may be counted in this category during each reporting period. Class, conference, or workshop presentations may be used for contact hour credit if the topic is germane to the field. A specific presentation given repeatedly can only be counted once. A particular presentation will qualify for contact hour credit one (1) time in a five (5) year period. Only actual presentation time may be counted; preparation time does not qualify for contact hour credit. The licensee must provide the Board with a copy of the conference program or a letter from the sponsor, host organization, or professional colleague. (3-29-12)

e. Clinical Supervision and Case Consultation. A maximum of five (5) contact hours of received supervision/consultation may be counted in this category during each reporting period. In order to qualify for contact hour credit, supervision/consultation must be received on a regular basis with a set agenda. No credit will be given for the licensee's supervision of others. The licensee must provide the Board with a letter from the supervisor or consultant listing periods of supervision~~, *where the supervision occurred, and the name of the supervisor*~~ or consultation. ~~*(3-29-10)*~~( )

f. Dissertation. A maximum of five (5) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a copy of the licensee's transcript and the title of the dissertation. (3-29-10)

g. Leadership. A maximum of four (4) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a letter from a professional colleague listing the position of leadership, periods of leadership, and the name of the organization under which the leadership took place. The following leadership positions qualify for continuing education credits: (3-29-10)

i. Executive officer of a state or national counseling or therapy organization; (3-29-12)

ii. Editor or editorial board service of a professional counseling or therapy journal; (3-29-12)

iii. Member of a national ethics disciplinary review committee rendering licenses, certification, or professional membership; (3-29-10)

iv. Active member of a counseling or therapy working committee producing a substantial written product; (3-29-10)

v. Chair of a major counseling or therapy conference or convention; or (3-29-10)

vi. Other leadership positions with justifiable professional learning experiences. (3-29-10)

h. Home Study and On-line Education. A maximum of ten (10) contact hours may be counted through self-study during each reporting period. In order for a home study or on-line course to qualify for contact hours, the course must be provided by a Board-approved continuing education provider or a course pre-approved by the Board. (3-29-12)

i. Copy of Certification Required. A licensee applying for home study or on-line credit must provide the Board a copy of the certification that is verified by the authorized signatures from the course instructors, providers, or sponsoring institution and substantiates any hours completed by the licensee. A licensee seeking contact credit for reading a publication must submit results from a test on the information contained within the publication and administered by an independent third-party. (3-29-10)

j. Continuing Education Credit. Continuing education credit may be granted for a maximum of two (2) hours each renewal period for time spent attending one (1) Board meeting. Members of the Board are not entitled to continuing education credit for Board service. (3-29-10)

04. Excess Hours. Continuing education hours accumulated during the twelve (12) months immediately preceding the license renewal date may be applied toward meeting the continuing education requirement for the next license renewal. No more than ten (10) hours in excess of the required twenty (20) hours shall be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. (3-29-12)

05. Compliance Audit. The Board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the Board of meeting the continuing education requirement be submitted to the Bureau. Failure to provide proof of meeting the continuing education upon request of the Board shall be grounds for disciplinary action in accordance with section 54-3407, Idaho Code. (4-2-03)

06. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must request such exemption prior to renewal and provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board. There is no continuing education required of those holding a current inactive license. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

501. -- 5~~49~~24. (RESERVED)

525. DOCUMENTATION OF INFORMED CONSENT (RULE 525).
In accordance with Section 54-3410A, Idaho Code, all licensees and registered interns will document the process of obtaining the informed consent of clients at the beginning of treatment and at other times as appropriate. Licensees and interns shall adhere to their respective Codes of Ethics and state law in obtaining informed consent and disclosing information to clients. The receipt of the disclosure shall be acknowledged in writing by both the client and the licensee or intern, and such disclosure of information concerning their practice must include: ( )

01. Name, Business Address and Phone Number of Licensee or Intern. If the licensee or intern is practicing under supervision, the statement shall include the licensee or intern status as such and the designated qualified supervisor's name, business address and phone number; ( )

02. License Type and License Number, Credentials, and Certifications; ( )

03. Education and Training. Formal education and training with the name(s) of the institution(s) attended and the specific degree(s) received; ( )

04. Theoretical Orientation and Approach. Counseling or marriage and family therapy; ( )

05. Relationship. Information about the nature of the clinical relationship; fee structure and billing arrangements; cancellation policy; ( )

06. The Extent and Limits of Confidentiality. ( )

07. Written Statement. A statement that sexual intimacy is never appropriate with a client and should be reported to the board. ( )

08. Client's Rights. The client's rights to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment. ( )

09. Board Information. The name, address, and phone number of the Board with the information that the practice of licensees and interns is regulated by the Board. ( )

526. -- 549. (RESERVED)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.17.01 - RULES OF THE STATE BOARD OF ACUPUNCTURE

DOCKET NO. 24-1701-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-4705, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 586 through 590**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208-334-3233.

DATED this 29th day of October, 2012.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
(208) 334-3233 Ph. (208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-4705, 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 October 17, 2012.

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 State Board of Acupuncture is clarifying its rules on the process for active and inactive licenses. It also is making changes to the continuing education requirements to create two (2) separate categories to help ensure that the continuing education is appropriate. The changes to the records section clarify the release of the patient's records. New rules are also created to provide for disclosure of fees to the patient; clarify the nature of activities performed by unlicensed employees and non-exempt individuals, provide for supervision of trainees and technicians; and clarify limits on advertising.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no impact on general or dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes and additions are an effort to clarify the rules and create standards for public safety. The proposed rules were discussed at scheduled noticed board meetings and submitted to the Acupuncture Association which expressed no concerns.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 October 24, 2012.

DATED this 30th day of August, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1701-1201

301. RENEWAL OR REINSTATEMENT OF LICENSE (RULE 301).

01. Expiration Date. All Acupuncture licenses and certificates expire and must be renewed annually on forms approved by the Board together with the required fee in accordance with Section 67-2614, Idaho Code. As part of a complete renewal application, the licensee will certify by signed affidavit completion of the required continuing education pursuant to Sections 305 through 307 of these rules. Licenses and certificates not so renewed will be cancelled in accordance with Section 67-2614, Idaho Code. ~~(5-3-03)~~( )

02. Reinstatement. Any license or certificate cancelled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code, with the exception that the reinstatement fee shall be two hundred fifty dollars ($250) and the applicant shall submit proof of having met the required continuing education for each year the license or certificate was cancelled. (5-3-03)

302. ~~*RENEWAL REQUIREMENT*~~ INACTIVE STATUS (RULE 302).

~~***01. Active Status**. Each renewal application must be accompanied by:* *(3-10-00)***~~

~~***a.** The established fee; and* *(3-10-00)***~~

~~***b.** Beginning July 1, 2004, certification of having attended and completed a minimum of fifteen (15) hours of acupuncture study or oriental medical theory and techniques within the previous twelve (12) months, as approved by the Idaho Board of Acupuncture.* *(3-20-04)***~~

~~***c.** Compliance with the continuing education (CE) requirements for licensees shall be reported annually. A CE course taken in any renewal year, but not claimed for CE credit in that year, may be utilized for credit in the following renewal year.* *(5-3-03)***~~

~~***02. Inactive Status**.~~ A currently licensed or certified practitioner may request in writing to have their license placed on inactive status and pay the inactive status fee. Such request must be made prior to the expiration date of the license, otherwise the license shall be deemed cancelled for failure to renew. ~~(5-3-03)~~( )

0~~3~~1. **Definition of Inactive Status**. "Inactive" status means an Idaho Acupuncture license that may be made active by paying the renewal fee. Until payment of said fee, such individual may not practice acupuncture in the state of Idaho. (5-3-03)

0~~4~~2. Waiving Continuing Education Requirements - Inactive Status. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing in Idaho. Inactive license renewal notices and licenses will be marked "Inactive." ~~*A licensee desiring active status must show acceptable fulfillment of continuing educational requirements for the current year and submit a fee equivalent to the difference between the inactive and active renewal fee. The continuing educational requirement and the fees will not be prorated for a partial year.* (5-3-03)~~( )

03. Return to Active Status. A licensee desiring active status must show acceptable fulfillment of continuing educational requirements for the current year and submit a fee equivalent to the difference between the inactive fee and renewal fee. The continuing educational requirement and the fees will not be prorated for a partial year. ( )

303. -- 304. (RESERVED)

305. CONTINUING EDUCATION REQUIREMENTS (RULE 305).
In order to further protect the public health and to facilitate the administration of the Acupuncture Act, the Board has ~~*formulated the following rules*~~ adopted the following requirements:
~~(5-3-03)~~( )

01. ~~*Subject Material*~~ Requirement. All practitioners, for renewal of their license or certificate, shall be required to complete a minimum of fifteen (15) hours of continuing education within the preceding twelve (12) months. Beginning July 1, 2014, a minimum of ten (10) hours of continuing education must be from Category I topics, and a maximum of five (5) hours of continuing education may be from Category II topics, as set forth in Sections 306 and 307 of these rules. ~~*(5-3-03)*~~( )

~~***a.*** *Accepted by NCCAOM, offered by accredited schools of acupuncture and oriental medicine, or otherwise approved by the Board.* (5-3-03)~~

~~***b.*** *"Germane to the practice of acupuncture" shall be consistent with Section 54-4702(1)(4), Idaho Code.* (5-3-03)~~

02. Verification of Attendance. It shall be necessary for each licensee to maintain verification of attendance by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any hours attended by the applicant. This verification shall be maintained by the licensee for no less than seven (7) years and provided to the Board upon the request of the Board or its agent. (5-3-03)

03. Distance Learning and Independent Study. The Board may approve a course of study for continuing education credit that does not include the actual physical attendance of the applicant in a face-to-face setting with the course instructor. Distance Learning or Independent Study courses shall be eligible for continuing education credits if approved by NCCAOM or upon approval of the Board. (4-6-05)

~~***04. Requests for Approval***. *All requests for approval or pre-approval of educational programs must be made to the Board in writing, and must be accompanied by a statement that*~~

~~*includes the name of the instructor or instructors, the date and time and location of the course, the specific agenda for the course, the number of continuing education credit hours requested, and a statement of how the course is believed to be pertinent to the practice of acupuncture.*~~

~~*(5-3-03)*~~

0~~5~~4. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.

(4-6-05)

05. Carryover. A continuing education course taken in a renewal year, but not claimed for continuing education credit in that year, may only be claimed for credit in the following renewal year. ( )

306. APPROVAL OF CONTINUING EDUCATION COURSES.

Approved continuing education courses shall be those courses, programs, and activities that meet the general requirements, the content requirements of these rules, and that are approved or provided by the following entities or organizations, or otherwise approved by the Board: ( )

01. NCCAOM; ( )

02. Accredited Schools. Acupuncture and oriental medicine; and ( )

03. Other Courses May Be Approved by the Board. Other courses may be approved based upon documentation submitted by the licensee or course provider. All requests for approval or pre-approval of educational programs must be made to the Board in writing, and must be accompanied by a statement that includes the name of the instructor or instructors, the date and time and location of the course, the specific agenda for the course, the number of continuing education credit hours requested, and a statement of how the course is believed to be pertinent to the practice of acupuncture. ( )

307. CONTENT OF CONTINUING EDUCATION COURSES.

The content of a continuing education course must be germane to the practice of acupuncture as defined in Section 54-4702, Idaho Code, and ( )

01. Category I. Category I courses shall relate to the following topics: ( )

a. Acupuncture and the practice of acupuncture as defined in Section 54-4702, Idaho Code including topics that directly concern the history and theory of acupuncture, oriental medicine diagnosis and treatment techniques, and techniques of adjunctive oriental medicine therapies; ( )

b. The role of acupuncture in individual and public health, such as emergencies and disasters; or ( )

c. Research and evidence-based medicine as related to acupuncture and Asian medicine; ( )

02. Category II. Category II courses shall relate to the following topics: ( )

a. Western biomedicine and biological sciences; ( )

b. Scientific or clinical content with a direct bearing on the quality of patient care, community or public health, or preventive medicine; ( )

c. Laws and ethics; ( )

d. Enhancement of effective communication with other medical practitioners; ( )

e. Behavioral sciences, patient counseling, and patient management and motivation when such courses are specifically oriented to the improvement of patient health; ( )

f. Practice management unrelated to clinical matters and direct patient care, including, but not limited to, administrative record keeping, insurance billing and coding, and general business organization and management; or ( )

g. Patient education including, but not limited to, patient education in East Asian therapeutic exercise techniques and Asian nutritional therapies. ( )

30~~6~~8. -- 399. (RESERVED)

401. RECORDS (RULE 401).
A practitioner shall keep accurate records of each patient the practitioner treats. The records shall include the name of the patient, the indication and nature of treatment given, and any other relevant data deemed important by the practitioner. Records shall be kept on file for a minimum of five (5) years and shall be open to inspection at any time by the Board or its duly authorized representative. ~~and~~ A patient's records shall be made available to the patient ~~on~~ within thirty (30) days of a request. Reasonable fees may be charged for copying the records. ~~(3-10-00)~~( )

402. DISCLOSURE OF FEES (RULE 402).
Prior to providing treatment to a new patient, a practitioner shall explain to the patient the fees expected for treatment, accepted methods of payment, and payment policies including when payment is expected and any fees or interest to be charged for late payments. Such explanations should be provided in writing. ( )

01. Payment. If the practitioner expects payment from the patient before receiving third party payments, the practitioner shall inform the patient before providing treatment. ( )

02. Fee Changes. If the practitioner's fees change during the course of treatment, the practitioner shall inform the patient of the new fees before providing treatment under the new fee schedule. ( )

403. EMPLOYMENT OF UNLICENSED, NON-EXEMPT INDIVIDUALS (RULE 403).
Individuals who do not have a license and are not exempt from licensure shall not perform any insertion of acupuncture needles or use similar devices and therapies, including application of

moxibustion. They may only support the practitioner's professional practice by performing office and ministerial acts related to acupuncture. The practitioner shall be responsible for the services provided by such employees. ( )

404. SUPERVISION OF TRAINEES AND TECHNICIANS (RULE 404).
A licensed or certified acupuncturist providing supervision to trainees or technicians shall be responsible for the services provided by such individuals. Failure to adequately supervise such an individual may subject the supervisor to discipline. ( )

405. ADVERTISING (RULE 405).
A practitioner shall not disseminate or cause the dissemination of any advertisement or advertising including offers, statements, or other representations, which is in any way fraudulent, false, deceptive, or misleading. Any advertisement or advertising shall be deemed by the board to be fraudulent, false, deceptive, or misleading if it: ( )

01. Contains a Misrepresentation of Fact. Contains a misrepresentation of fact; ( )

02. Misleading or Deceptive. Is misleading or deceptive because in its content or in the context in which it is presented it makes only a partial disclosure of relevant facts. It is misleading and deceptive for a practitioner to advertise free or services for a specific charge when in fact the practitioner is transmitting a higher charge for the advertised services to a third party payor for payment or charges the patient or a third party. It is misleading and deceptive for a practitioner to use the word "Doctor" in offering to perform services without also indicating the profession in which the licensee holds a doctorate level degree. ( )

03. Creates False or Unjustified Expectations of Beneficial Treatment or Successful Cures. Creates false, or unjustified expectations of beneficial treatment or successful cures; ( )

04. Failure to Perform. Contains any representations or claims, as to which the practitioner, referred to in the advertising, fails to perform; or ( )

05. Deceptive or Misleading Heading. Appears in any classified directory, listing, or compendium under a heading, which when considered together with the advertisement, has the capacity or tendency to be deceptive or misleading with respect to the profession or professional status of the practitioner. ( )

402~~2~~6. -- 499. (RESERVED)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1201

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

A detailed summary of the reason for adopting this rulemaking is set forth in the initial proposed rulemaking. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 621 through 634**. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin.

The Board of Pharmacy received public comment regarding one grammatical error that is being corrected with the addition of the word “and” in Paragraph 013.01.b.; the use of the term “clinic” that is being deleted as no longer necessary in Subparagraph 021.03.b.iii.; the necessity for continuing education to maintain qualification to administer vaccines which is being added in Subsection 052.05; clarification on valid prescription orders and the allowance of statutory exemptions which is being added in Paragraph 110.01.e.; and clarification on the requirements for the transfer of prescription drug orders which necessitated adding the serial number in Subparagraph 115.03.g.ii.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

DATED this 30th day of November, 2012.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to 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 October 17, 2012.

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:

These changes are needed for ease of reading and are mostly non-substantive. The rule changes included in this proposed docket are housekeeping in nature, as that they move a sub-rule, clarify renewal dates, rename registration categories, correct punctuation, change a rule number, strike extraneous verbiage, include references to recent changes to Idaho Code, harmonize terminology, and change a title.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012 Idaho Administrative Bulletin, **Vol. 12-5, Page 82**, and in the August 1, 2012 Idaho Administrative Bulletin, **Vol. 12-8, page 73**, Docket No. 27-0101-1201.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

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 October 24, 2012.

DATED this 5th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1201

013. WAIVERS OR VARIANCES.

01. Criteria. The Board may grant or deny, in whole or in part, a waiver of, or variance from, specified Board rules based on consideration of the following: (3-21-12)

a. The application of a certain rule or rules is unreasonable and would impose an undue hardship or burden on the petitioner; (3-21-12)

b. The waiver or variance requested would not allow conduct specifically prohibited by, or otherwise contrary to, state or federal law; and ~~*(3-21-12)*~~( )

c. The granting of the waiver or variance is consistent with the Board's mandate to promote, preserve, and protect public health, safety, and welfare~~*; and*~~ ~~*(3-21-12)*~~( )

~~***d.*** *The granting of the waiver or variance will afford substantially equal protection of public health, safety, and welfare intended by the particular rule for which the waiver or variance is requested.* *(3-21-12)*~~

02. Content and Filing of a Waiver or Variance Petition. A petition for waiver or variance must be submitted in writing and must include at least the following: (3-21-12)

a. The name, address, and telephone number of the petitioner; (3-21-12)

b. A specific reference to the rule or rules from which a waiver or variance is requested; (3-21-12)

c. A statement detailing the waiver or variance requested, including the precise scope

and duration; (3-21-12)

d. The name, address, and telephone number of any public agency or political subdivision that also regulates the activity in question or that might be affected by the granting of the waiver or variance; and (3-21-12)

e. The name, address, and telephone number of any known person who would be adversely affected by the granting of the waiver or variance. (3-21-12)

f. A description of how the waiver or variance, if granted, will afford substantially equal protection of public health, safety, and welfare intended by the particular rule for which the waiver or variance is requested. ( )

03. Additional Information. Prior to granting or denying the waiver or variance, the executive director may request additional information from the petitioner and may require the petitioner to appear before the Board at an upcoming Board meeting. (3-21-12)

04. Granting or Denying the Petition for Waiver or Variance. The decision to grant or deny the petition for waiver or variance will be at the discretion of the Board or, pursuant to Board authorization, its executive director based upon consideration of relevant factors. (3-21-12)

05. Prohibited Requests. A waiver or variance request that is contrary to federal law or Idaho Code or that seeks to delay or cancel an administrative deadline will not be considered or granted by the Board. (3-21-12)

06. Conditions. Waivers or variances may be granted subject to binding conditions, limitations, or restrictions determined necessary to protect the public health, safety, and welfare. (3-21-12)

07. Time Period of Waiver or Variance. Waivers or variances may be granted on a permanent or temporary basis. Temporary waivers or variances have no automatic renewal, but may be renewed if the Board finds that sufficient grounds to allow the waiver or variance continue to exist. (3-21-12)

08. Cancellation or Modification of a Waiver or Variance. A waiver or variance granted by the Board may be cancelled or modified if the Board finds any of the following: (3-21-12)

a. The petitioner or other person who was the subject of the waiver or variance withheld or misrepresented material facts; (3-21-12)

b. The alternative means for ensuring adequate protection of public health, safety, or welfare are demonstrated to be insufficient after issuance of the waiver or variance; or (3-21-12)

c. The subject of the waiver or variance has failed to comply with the prescribed conditions, limitations, or restrictions of the waiver or variance. (3-21-12)

09. Violations. Violation of a condition, restriction, or limitation of a waiver or

variance will be deemed a violation of the particular rule or rules for which the waiver or variance was granted. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

016. BOARD OF PHARMACY LICENSURE AND REGISTRATION.
The Board is responsible for the control and regulation of the practice of pharmacy in or into the state of Idaho, which includes the licensure or registration of professional, supportive, and ancillary personnel who engage in or support the practice. The Board is also responsible for the control, regulation, and registration of persons or drug outlets that manufacture, distribute, or dispense controlled substances within or into the state. Licenses or registrations required by state or federal law, or both, must be obtained prior to engaging in these practices or their supportive functions. (3-21-12)

01. Pharmacy Practice Act Licenses and Registrations. The Board will issue or renew a license or a certificate of registration upon application and determination that the applicant has satisfied the requirements of the Idaho Pharmacy Act and any additional criteria specified by these rules for the license or registration classification. Licenses and certificates of registration issued pursuant to Title 54, Chapter 17, Idaho Code, expire annually on June 30 unless an alternate expiration term or date is specifically stated in these rules. (3-21-12)

02. Idaho Controlled Substances Act Registrations. The Board will issue or renew controlled substance registrations upon application and determination that the applicant has satisfied the requirements of the Idaho Controlled Substances Act and any additional criteria specified by state or federal law applicable to applicants that manufacture, distribute, or dispense, or conduct research with, controlled substances. Registrations issued pursuant to Title 37, Chapter 27, Idaho Code, ~~*expire*~~ must be renewed annually ~~*on*~~ by June 30 for pharmacists and ~~*on*~~ by December 31 for all other registrants. ~~*(3-21-12)*~~( )

a. Unless a wholesaler, an applicant for an Idaho controlled substance registration must hold a valid, unrestricted Idaho license to prescribe, dispense, or administer controlled substances and, unless a pharmacist or certified euthanasia technician, a valid federal DEA registration. If a required license or registration is cancelled or otherwise invalidated by the issuing agency, the Idaho controlled substance registration will be correspondingly cancelled. (3-21-12)

b. A registrant engaging in more than one (1) group of independent activities, as defined by federal law, must obtain a separate Idaho controlled substance registration for each group of activities if not exempted from separate DEA registration by federal law. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

018. LICENSE AND REGISTRATION: REINSTATEMENT.
The Board may, at its discretion, consider reinstatement of a license or registration upon receipt of a written petition and payment of the reinstatement and other fees due or delinquent at the time reinstatement is requested. (3-21-12)

01. Satisfactory Evidence. If applicable, reinstatement applicants must also provide satisfactory evidence of completion of continuing education requirements and compliance with any direct orders of the Board. (3-21-12)

02. Additional Requirements. A pharmacist reinstatement applicant must provide evidence of completion of a minimum of thirty (30) CPE~~U~~s hours within the twenty-four (24) months prior to reinstatement application and may be required to appear before the Board. The Board may also, at its discretion, impose additional requirements on a pharmacist reinstatement applicant who has not practiced as a pharmacist for the preceding twelve (12) months or longer that may include taking and passing an examination, completion of forty (40) intern hours for each year away from the practice of pharmacy, completion of additional CPE~~U~~s hours, or other requirements determined necessary to acquire or demonstrate professional competency.
~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

021. FEE SCHEDULE.

01. Licenses -- Professionals. (3-21-12)

a. Original pharmacist license: one hundred dollars ($100). (3-21-12)

b. Licensure by reciprocity: two hundred fifty dollars ($250). (3-21-12)

c. Pharmacist license annual renewal. (3-21-12)

i. Active: ninety dollars ($90). (3-21-12)

ii. Inactive: fifty dollars ($50). (3-21-12)

d. Late payment processing: fifty dollars ($50). (3-21-12)

e. License reinstatement fee: seventy-five dollars ($75). (3-21-12)

02. Certificates of Registration -- Professionals. (3-21-12)

a. Pharmacist engaged in telepharmacy across state lines -- registration or annual renewal: two hundred fifty dollars ($250). (3-21-12)

b. Pharmacist intern - registration or annual renewal: fifty dollars ($50). (3-21-12)

c. Pharmacist extern registration and annual renewal: fifty dollars ($50) due upon enrollment in an accredited school or college of pharmacy and renewed annually at no charge. (3-21-12)

d. Technician - registration or annual renewal: thirty-five dollars ($35). (3-21-12)

e. Veterinary drug technician - registration or annual renewal: thirty-five dollars ($35). (3-21-12)

f. Registration reinstatement: one-half (1/2) the amount of the annual fee. (3-21-12)

03. Certificates of Registration and Licensure - Facilities. (3-21-12)

a. Retail pharmacy - registration or annual renewal: one hundred dollars ($100). (3-21-12)

b. Institutional facility - registration or annual renewal. (3-21-12)

i. Hospital pharmacy: one hundred dollars ($100). (3-21-12)

ii. Nursing home: thirty-five dollars ($35). (3-21-12)

~~*iii. Hospital without a pharmacy: thirty-five dollars ($35).* (3-21-12)~~

c. Manufacturer (including a repackager that is a manufacturer's authorized distributor of record) - registration or annual renewal: one hundred dollars ($100). (3-21-12)

d. Wholesaler. (3-21-12)

i. License or annual renewal: one hundred thirty dollars ($130); or (3-21-12)

ii. Registration or annual renewal: one hundred dollars ($100). (3-21-12)

e. Veterinary drug outlet - registration or annual renewal: one hundred dollars ($100). (3-21-12)

f. Telepharmacy across state lines - registration or annual renewal: one hundred dollars ($100). (3-21-12)

g. Mail service pharmacy. (3-21-12)

i. Initial license: five hundred dollars ($500). (3-21-12)

ii. License annual renewal: two hundred fifty dollars ($250). (3-21-12)

h. Limited service outlet - registration or annual renewal. (3-21-12)

i. Limited service outlet, if not listed: one hundred dollars ($100). (3-21-12)

ii. ~~*Parenteral admixture*~~ Sterile product pharmacy: one hundred dollars ($100). ~~*(3-21-12)*~~( )

iii. Remote dispensing pharmacy: one hundred dollars ($100). (3-21-12)

iv. Facility operating a narcotic treatment program: one hundred dollars ($100). (3-21-12)

v. Durable medical equipment outlet: fifty dollars ($50). (3-21-12)

vi. Prescriber drug outlet: thirty five dollars ($35). (3-21-12)

i. Analytical or research lab -- registration or annual renewal: forty dollars ($40). (3-21-12)

j. Retail non-pharmacy outlets - registration or annual renewal. (3-21-12)

i. "A" (Stocks more than fifty (50) drug items): sixty dollars ($60). (3-21-12)

ii. "B" (Stocks fifty (50) or fewer drug items): twenty-five dollars ($25). (3-21-12)

iii. "V" (Vending machines): ten dollars ($10) per machine. (3-21-12)

k. Supplemental facility registrations or annual renewals. (3-21-12)

i. Laminar flow or other hood, biological safety cabinet, or barrier isolator -- single registration required for one (1) or more hoods: no charge. (3-21-12)

ii. ADS system -- single registration required for one (1) or more systems: no charge. (3-21-12)

l. Reinstatement: one-half (1/2) the amount of the annual fee. (3-21-12)

04. Controlled Substance Registration. (3-21-12)

a. Controlled substance - registration or annual renewal: sixty dollars ($60). (3-21-12)

b. Wholesaler or distributor-controlled substance - registration or annual renewal: one hundred dollars ($100). (3-21-12)

c. Controlled substance registration reinstatement: seventy-five dollars ($75). (3-21-12)

05. Administrative Services and Publications. (3-21-12)

a. Experiential hours certification: twenty-five dollars ($25). (3-21-12)

b. Duplicate pharmacist certificate of licensure: thirty-five dollars ($35). (3-21-12)

c. Duplicate registration or license card: ten dollars ($10). (3-21-12)

d. Commercial lists. (3-21-12)

i. Pharmacy list: fifty dollars ($50). (3-21-12)

ii. Pharmacist list: fifty dollars ($50). (3-21-12)

iii. Controlled Substances Act ("CSA") registrant list: one hundred fifty dollars ($150). (3-21-12)

e. Official Idaho Register: fifteen dollars ($15). (3-21-12)

f. Idaho Pharmacy Laws and Rules book: thirty-five dollars ($35). (3-21-12)

g. Hearing transcript: five dollars ($5) per page. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

034. PHARMACIST INACTIVE STATUS LICENSE.

01. Required Criteria. Upon Board approval, an inactive status pharmacist license may be issued if an applicant: (3-21-12)

a. Is a pharmacist in the state of Idaho licensed in good standing; (3-21-12)

b. Is unable or unwilling to practice pharmacy due to physical limitations or changes in circumstance; and (3-21-12)

c. Has submitted the required application. (3-21-12)

02. Exemptions and Restrictions. Inactive status licensees are exempt from CPE requirements and are prohibited from engaging in the practice of pharmacy while on inactive status. (3-21-12)

03. Return to Active Status. If an inactive status licensee wishes to return to active status, the licensee must ~~*complete a minimum of thirty (30) CPEUs and*~~ comply with the reinstatement requirements of these rules. ~~*(3-21-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

052. CPE: REQUIREMENTS.
Each pharmacist applicant for license renewal must annually complete ~~*the equivalent of one and one-half (1.5)*~~ fifteen (15) CPE ~~*units (CPEU)*~~ hours. ~~*One (1) CPEU is the equivalent of ten (10) clock hours of participation in programs approved by the Board.*~~ ~~*(3-21-12)*~~( )

01. ACPE or CME. At a minimum, eight (8) ~~*clock*~~ of the CPE hours ~~*(0.8 CPEU)*~~ obtained must be all or a combination of ACPE or CME accredited programs. ACPE accredited activities must have a participant designation of "P" (for pharmacist) as the suffix of the ACPE universal program number. ~~*(3-21-12)*~~( )

02. Pharmacy Law. One (1) ~~*clock*~~ of the CPE hours ~~*(0.1 CPEU)*~~ obtained must be ACPE accredited or Board approved jurisprudence (pharmacy law) programs. ~~*(3-21-12)*~~( )

03. Board Approved. A maximum of six (6) ~~*clock*~~ of the CPE hours ~~*(0.6 CPEU)*~~ obtained may be Board-approved programs not accredited through ACPE or CME. ~~*(3-21-12)*~~( )

04. Live Attendance. Three (3) ~~*clock*~~ of the CPE hours ~~*(0.3 CPEU)*~~ obtained must be ~~*obtained*~~ by attendance at live or synchronous online CPE programs. ~~*(3-21-12)*~~( )

***05. Immunizer Qualification**. To maintain qualification to administer immunizations, a minimum of one (1) of the ACPE-approved CPE hours must be related to vaccines, immunizations, or their administration.* *( )*

0~~5~~6. Carryover of Certain Unused Units. ~~*Clock*~~ CPE hours ~~*of CPEU*~~ accrued during June of a licensing period may be carried over into the next licensing period to the extent that a pharmacist's total ~~*clock*~~ CPE hours ~~*of CPEU*~~ for the current licensing period exceed the total CPE~~U~~s hours required by these rules. ~~*(3-21-12)*~~( )

0~~6~~7. New Pharmacist Exemption. Recent pharmacist graduates applying for the first license renewal are not required to complete or certify the annual CPE requirements. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

110. PRESCRIPTION DRUG ORDER: VALIDITY.
Prior to filling or dispensing a prescription drug order, a pharmacist must verify its authenticity and validity. (3-21-12)

01. Invalid Prescription Drug Orders. A prescription drug order is invalid if not issued: (3-21-12)

a. In good faith; (3-21-12)

b. For a legitimate medical purpose; (3-21-12)

c. By a licensed prescriber; (3-21-12)

d. Within the course and scope of the prescriber's professional practice and prescriptive authority; (3-21-12)

e. Pursuant to a *valid* prescriber-patient relationship, unless statutorily exempted; and ~~*(3-21-12)*~~( )

f. In the form and including the elements required by law. (3-21-12)

02. Antedating or Postdating. A prescription drug order is invalid if antedated or postdated. (3-21-12)

03. Tampering. A prescription drug order is invalid if it shows evidence of alteration, erasure, or addition by any person other than the person who wrote it. (3-21-12)

04. Prescriber Self-Use. A prescription drug order written for a controlled substance is invalid if written for the prescriber's own use. (3-21-12)

05. Family Members. A prescription drug order written for a prescriber's family member is invalid if inconsistent with the scope of practice and prescriptive authority of the prescriber's profession. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

115. PRESCRIPTION DRUG ORDER: TRANSFERS.

01. Communicating Prescription Drug Order Transfers. Except prescription drug orders for Schedule II controlled substances, a pharmacist may transfer prescription drug order information for the purpose of filling or refilling if the information is communicated from pharmacist to pharmacist verbally, electronically, or via fax. (3-21-12)

a. Prescription drug order information may also be communicated verbally by a student pharmacist, under the supervision of a pharmacist, to another pharmacist as long as one (1) of the parties involved in the communication is a pharmacist. (3-21-12)

b. If transferring by fax transmission, the transfer document used must be signed by the transferring pharmacist. (3-21-12)

02. Documentation Required of the Transferring Pharmacy. The pharmacist transferring prescription drug order information must void or otherwise indicate that the original prescription drug order has been transferred and record the following information: (3-21-12)

a. The name of the transferring pharmacist; (3-21-12)

b. The name of the receiving pharmacist; (3-21-12)

c. The name of the receiving pharmacy; (3-21-12)

d. The date of the transfer; (3-21-12)

e. The number of authorized refills available; and (3-21-12)

f. If written for a controlled substance, the address and DEA registration number of the receiving pharmacy. (3-21-12)

03. Documentation Required of the Receiving Pharmacy. The pharmacist receiving a transferred prescription drug order must document that the prescription drug order is a "transfer" and record the following information: (3-21-12)

a. The name of the receiving pharmacist; (3-21-12)

b. The name of the transferring pharmacist; (3-21-12)

c. The name of the transferring pharmacy; (3-21-12)

d. The date of issuance of the original prescription drug order; (3-21-12)

e. The number of refills authorized by the original prescription drug order; (3-21-12)

f. The number of authorized refills available; and (3-21-12)

g. If written for a controlled substance: (3-21-12)

i. The dates and locations of the original dispensing and previous refills; and (3-21-12)

ii. The name, address, DEA registration number, and the serial number assigned to the prescription ~~*number of*~~ by the transferring pharmacy ~~*for each dispensing*~~ and ~~*of the*~~ *any additional* pharmacy that ~~*originally*~~ filled the prescription, if ~~*different*~~ *applicable*.~~*(3-21-12)*~~( )

04. Electronic Prescription Drug Order Transfers. For electronic prescription drug orders that are transferred electronically, the transferring pharmacist must provide all of the information required to be recorded by the receiving pharmacist in addition to the original electronic prescription data. The receiving pharmacist must create an electronic record for the prescription drug order that includes the receiving pharmacist's name and all of the information transferred with the prescription. (3-21-12)

05. Pharmacies Using Common Electronic Files. Pharmacies may establish and use a common electronic file to maintain required dispensing information. (3-21-12)

a. Pharmacies using a common electronic file are not required to transfer prescription drug order information for dispensing purposes between or among other pharmacies sharing the common electronic file. (3-21-12)

b. Common electronic files must contain complete and accurate records of each prescription and refill dispensed. (3-21-12)

06. Transferring Prescription Drug Orders for Controlled Substances. A prescription drug order for a controlled substance listed in Schedules III, IV, or V may be transferred only from the pharmacy where it was originally filled and never from the pharmacy that received the transfer, except that pharmacies electronically sharing a real-time, online database may transfer up to the maximum refills permitted by law and the prescriber's authorization. (3-21-12)

07. Transferring Prescription Drug Order Refills. Prescription drug orders for non-controlled substances may be transferred more than one (1) time if there are refills remaining and other legal requirements are satisfied. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

204. CONTROLLED SUBSTANCES: PMP.
Specified data on controlled substances must be reported weekly, or more often as required by the Board, by all pharmacies holding a DEA retail pharmacy registration that dispense controlled substances in or into Idaho and prescribers that dispense controlled substances to humans. Data on controlled substance prescription drug samples does not need to be reported. ~~(3-21-12)~~( )

01. Online Access to PMP. Online access to the Board's PMP is limited to licensed prescribers and pharmacists for treatment purposes. To obtain online access, a prescriber or pharmacist must: (3-21-12)

a. Complete and submit a registration application and a written agreement to adhere to the access restrictions and limitations established by law; (3-21-12)

b. Obtain Board approval for access; and (3-21-12)

c. Be issued a user account, login name, and password. (3-21-12)

02. Use Outside Scope of Practice Prohibited. Information obtained from the PMP must not be used for purposes outside the prescriber's or pharmacist's scope of professional practice. (3-21-12)

03. Profile Requests. Authorized persons without online access may obtain a profile by completing the required form and submitting it to the Board office with proof of identification and other credentials required to confirm the requestor's authorized status pursuant to Section 37-

2726, Idaho Code. (3-21-12)

04. Suspension, Revocation, or Restriction of PMP Access. Violation of this rule provides grounds for suspension, revocation, or restriction of the prescriber's or pharmacist's authorization for online access to the PMP. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

330. PHARMACIST: ADMINISTERED IMMUNIZATIONS.

01. Patient Eligibility. A pharmacist may administer an immunization to a healthy patient without immunization contraindications pursuant to the latest recommendations by the CDC or other qualified government authority or to any patient pursuant to a prescription drug order issued by another prescriber. (3-21-12)

02. Pharmacist Qualifications. To qualify to administer immunizations, a pharmacist must first: (3-21-12)

a. Successfully complete an ACPE-accredited or comparable course that meets the standards for pediatric, adolescent, and adult immunization practices recommended and approved by the CDC's Advisory Committee on Immunization Practices and includes at least the following: (3-21-12)

i. Basic immunology, vaccine, and immunization protection; (3-21-12)

ii. Diseases that may be prevented by vaccination or immunization; (3-21-12)

iii. Current recommended immunization schedules; (3-21-12)

iv. Vaccine and immunization storage and management; (3-21-12)

v. Informed consent; (3-21-12)

vi. Physiology and techniques for administration of immunizations; (3-21-12)

vii. Pre-immunization and post-immunization assessment and counseling; (3-21-12)

viii. Immunization reporting and records management; and (3-21-12)

ix. Identification response, documentation, and reporting of adverse events. (3-21-12)

b. Hold a current certification in basic life support for healthcare providers offered by the American Heart Association or a comparable Board-recognized certification program that includes cardiopulmonary resuscitation (CPR) and automated electronic defibrillator (AED) training and requires a hands-on skills assessment by an authorized instructor. (3-21-12)

03. Maintaining Qualification. To maintain qualification to administer immunizations, a pharmacist must annually complete a minimum of one (1) ~~clock~~ CPE hour ~~(0.1 CPEU)~~ of ACPE-approved CPE related to vaccines, immunizations, or their administration, which may also be applied to the general CPE requirements of these rules. ~~(3-21-12)~~( )

04. Student Pharmacist Administration. A pharmacist may not delegate authority to administer immunizations; however, a student pharmacist who has satisfied the qualifications may administer immunizations under the direct supervision of a qualified immunizing pharmacist. (3-21-12)

05. Waste Disposal. An immunizing pharmacist must properly dispose of used or contaminated supplies. (3-21-12)

06. Required Reports. An immunizing pharmacist must report: (3-21-12)

a. Adverse events to the healthcare provider identified by the patient, if any, and to the Vaccine Adverse Event Reporting System (VAERS); and (3-21-12)

b. Administration of immunizations to the Idaho Immunization Reminder Information System (IRIS), as required. (3-21-12)

07. Required Resources. A pharmacist must have a current copy of, or on-site access to, the CDC's Epidemiology and Prevention of Vaccine-Preventable Diseases. (3-21-12)

08. Vaccine Information Statements. A corresponding, current CDC-issued VIS must be provided to the patient or the patient's representative for each administered immunization. (3-21-12)

09. Recordkeeping. For each administered immunization, the following information must be collected and maintained in the patient profile: (3-21-12)

a. The patient's name, address, date of birth, and known allergies; (3-21-12)

b. The date of administration; (3-21-12)

c. The product name, manufacturer, dose, lot number, and expiration date of the vaccine; (3-21-12)

d. Documentation identifying the VIS provided; (3-21-12)

e. The site and route of administration and, if applicable, the dose in a series (e.g. one (1) of three (3)); (3-21-12)

f. The name of the patient's healthcare provider, if any; (3-21-12)

g. The name of the immunizing pharmacist and of the student pharmacist, if any; (3-21-12)

h. Adverse events observed or reported, if any, and documentation including at least the dates of any subsequent required reporting; and (3-21-12)

i. Completed informed consent forms. (3-21-12)

10. Emergencies. (3-21-12)

a. An immunizing pharmacist must maintain an immediately retrievable emergency kit sufficiently stocked to manage an acute allergic reaction to an immunization. (3-21-12)

b. An immunizing pharmacist may initiate and administer auto-inject epinephrine, intramuscular diphenhydramine, or oral diphenhydramine to treat an acute allergic reaction to an immunization pursuant to guidelines issued by the American Pharmacy Association. (3-21-12)

331. -- 3~~4~~5~~9~~9. (RESERVED)

3~~5~~6~~0~~0. STUDENT PHARMACIST: UTILIZATION AND PRACTICE LIMITATIONS.

01. Activities. A student pharmacist may engage in the practice activities of a pharmacist if: (3-21-12)

a. The activity is not specifically required to be performed only by a pharmacist; (3-21-12)

b. The activity is commensurate with the education and skill of the student pharmacist and performed under the supervision of a pharmacist; (3-21-12)

c. Any activity of a compounding, dispensing, or interpretive nature is checked by a pharmacist; and (3-21-12)

d. Any recording activity that requires the initial or signature of a pharmacist is countersigned by a pharmacist. (3-21-12)

02. Unlawful Acceptance of Assignment. A student pharmacist must not accept assignment of, or perform, any task or function connected with pharmacy operations unless the student pharmacist is authorized by the assigning pharmacist and the task or function meets the criteria set forth in this rule. (3-21-12)

03. Identification of Student Pharmacists. (3-21-12)

a. Each student pharmacist must be identified by a clearly visible name badge designating the individual as a student pharmacist. The name badge must contain the individual's printed first name and the title of student pharmacist, pharmacist intern, pharmacist extern, or another title that conveys the same meaning. (3-21-12)

b. Student pharmacists must identify themselves as a student pharmacist, pharmacist intern, or pharmacist extern on any phone calls initiated or received while on duty. (3-21-12)

3~~5~~6~~1~~. -- 399. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

601. PHARMACY SPACE AND FIXTURES.

01. Preparation Area Standards. A pharmacy must be well-lit, ventilated, temperature controlled, and have sufficient floor and counter space to avoid overcrowding and to allow the pharmacy to be maintained in a clean and sanitary condition appropriate for the safe preparation and compounding of prescriptions. (3-21-12)

02. Equipment and Fixture Standards. A pharmacy must be equipped with a sink with hot and cold water, appropriate fixtures for waste disposal, and refrigerated storage equipment of reasonable capacity. (3-21-12)

03. Additional Retail Pharmacy Requirements. A retail pharmacy that is new or remodeled after the effective date of this rule must: (3-21-12)

a. Provide and maintain a patient consultation area that affords the patient auditory and visual privacy, is accessible through an entrance and exit that does not require the patient to enter or traverse any part of the ~~*prescription preparation or drug storage*~~ secured area~~s~~ of the pharmacy, and is compliant with the Americans with Disabilities Act; and ~~*(3-21-12)*~~( )

b. Include a lavatory facility in the pharmacy restricted to pharmacy staff. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

631. INSTITUTIONAL FACILITY: EMERGENCY DRUG ACCESS AND PHARMACIST ABSENCE.
The director must make advance arrangements necessary to facilitate continuity of patient care and for the provision of drugs to the medical staff and other authorized personnel of the institutional facility in emergencies and during the absences of a pharmacist in compliance with this rule. (3-21-12)

01. Emergency Pharmacy Access. If a drug is unavailable from any other authorized emergency source in sufficient time to prevent risk of harm to a patient that would result from a delay in obtaining the drug and in the absence of a pharmacist from the premises of the institutional facility, it may be retrieved from an institutional pharmacy by an R.N. as follows: (3-21-12)

a. One (1) R.N. may be designated per shift for emergency access to the pharmacy;

(3-21-12)

b. Access may only occur if controlled substances are secured in a locked cabinet or other appropriate means to prevent unauthorized access; and (3-21-12)

c. Only a non-controlled substance may be removed and only in an amount necessary to treat a patient's immediate need until the pharmacy is again attended by a pharmacist. (3-21-12)

02. Emergency Cabinets. A cabinet or similar enclosure located outside an institutional pharmacy may be used for emergency access of drugs by an R.N. as follows: (3-21-12)

a. The emergency cabinet must be accessible only by key, combination, or otherwise sufficiently secured to deny access to unauthorized persons; and (3-21-12)

b. Drugs stocked in the emergency cabinet must be approved, prepared, stored, and handled as specified by these rules for emergency drug supplies. (3-21-12)

03. Emergency Drug Access Conditions and Documentation. Emergency access by an R.N. to an institutional pharmacy or an emergency cabinet or similar enclosure must be documented as follows: (3-21-12)

a. Removal of a drug must be pursuant to a valid drug order; (3-21-12)

b. Removal of a drug must be documented in a record that includes at least: (3-21-12)

i. The patient's name and location; (3-21-12)

ii. The name and strength of the drug; (3-21-12)

iii. The amount; (3-21-12)

iv. The date and time; and (3-21-12)

v. The ~~*signature*~~ initials or other unique identifier of the designated nurse. ~~*(3-21-12)*~~( )

c. The removal record and a copy of the drug order must be left conspicuously in the pharmacy, emergency cabinet, or alternative location to facilitate prompt accuracy verification and initialing by a pharmacist. (3-21-12)

04. Temporary Pharmacist Absence. To accommodate periods of temporary absence of a pharmacist from the institutional pharmacy, pharmacy students and technicians may remain within the pharmacy under the following conditions: (3-21-12)

a. No other person may be allowed access or entrance to the pharmacy; (3-21-12)

b. Drugs or devices may not leave the pharmacy except if requested by, and immediately delivered to, the pharmacist; and (3-21-12)

c. Neither student pharmacists nor technicians may remain in the pharmacy during periods of pharmacist absence from the institutional facility. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

640. INSTITUTIONAL FACILITY: OFFSITE PHARMACY PRACTICE STANDARDS.

01. Offsite Pharmacy Services. If an institutional facility without an institutional pharmacy obtains drugs, devices, or other pharmacy services from outside the institutional facility, arrangements must be made to ensure that the offsite pharmacy provides services with sufficient professionalism, quality, and availability to adequately protect the safety of the patients and properly serve the needs of the facility. (3-21-12)

02. Written Agreement. The arrangements must be made in writing and must, at a minimum, specify that: (3-21-12)

a. An offsite pharmacist will act in the capacity of a part-time director; (3-21-12)

b. For nursing homes, on-call services by a pharmacist will be available at all times; (3-21-12)

c. The pharmacy will provide adequate storage facilities for drugs; and (3-21-12)

d. Drugs housed in an LTCF must be labeled as required by the ~~*general provisions of these*~~ standard prescription drug labeling rule~~s~~ and, unless maintained in an electronic record, must include a lot number for administration of recalls. ~~*(3-21-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

750. DME OUTLET STANDARDS.

01. Policies and Procedures. A DME outlet must adopt policies and procedures that establish: (3-21-12)

a. Operational procedures for the appropriate provision and delivery of equipment; (3-21-12)

b. Operational procedures for maintenance and repair of equipment; and (3-21-12)

c. Recordkeeping requirements for documenting the acquisition and provision of products. (3-21-12)

02. ~~*DME Outlet*~~ Sale of Specified Prescription Drugs. Registered DME outlets may hold for sale at retail the following prescription drugs: ~~*(3-21-12)*~~( )

a. Pure oxygen for human application; (3-21-12)

b. Nitrous oxide; (3-21-12)

c. Sterile sodium chloride; and (3-21-12)

d. Sterile water for injection. (3-21-12)

03. Prescriber's Order Required. Prescription drugs and devices may only be sold or delivered by a DME outlet upon the lawful order of a prescriber. DME outlets may hold drugs that are not prescription drugs for sale. (3-21-12)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1202

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 635 through 652**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Johnston, Executive Director, at (208) 334-2356 or at **mark.johnston@bop.idaho.gov**.

DATED this 30th day of November, 2012.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to 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 October 17, 2012.

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:

Post 2012 complete rule re-write, this rulemaking docket clarifies confusing, absent, and incomplete language. The rulemaking will add, strike and clarify definitions; add an acronym; harmonize terms; reduce license and registration posting requirement; clarify that technicians-in-training must obtain and maintain employment; clarify that student pharmacists and technician registrations may be cancelled if the registrants no longer meet the minimum requirements; clarify student pharmacist registration; clarify that a prescriber can designate "brand only" verbally; clarify who initials certain labels; clarify who is exempt from obtaining positive identification; reintroduce previously struck seven-day allowance for annual inventory; clarify that all drugs must be stored according to rule; clarify that prescriptions can be delivered to a correctional facility; clarify that a pharmacy can not open without a pharmacist-in-charge or a director; clarify the conditions when a pharmacist may be absent from a retail pharmacy while the pharmacy remains open; add a grandfathering provision to a security requirement; clarify the required public notification by a pharmacy of its change in hours open for business; clarify pharmacy permanent closing procedures; clarify that a director must notify the Board of a change in employment; clarify the conditions under which dispensing can occur by a hospital's emergency room; and clarify out-of-state mail service pharmacy's toll free access by patients, and reestablish conditions for drug returns.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking

was published in the May 2, 2012 Idaho Administrative Bulletin, **Vol. 12-5, Page 82**, and in the August 1, 2012 Idaho Administrative Bulletin, **Vol. 12-8, page 73**, Docket No. 27-0101-1201.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

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 October 24, 2012.

DATED this 5th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1202

010. DEFINITIONS AND ABBREVIATIONS (A -- I).

01. Accredited School or College of Pharmacy. A school or college that meets the minimum standards of the ACPE and appears on its list of accredited schools or colleges of pharmacy. (3-21-12)

02. ACPE. Accreditation Council for Pharmacy Education. (3-21-12)

03. Acute Care Hospital. A facility in which concentrated medical and nursing care is provided by, or under the supervision of, physicians on a twenty-four (24) hour basis to inpatients experiencing acute illnesses. (3-21-12)

04. ADS -- Automated Dispensing and Storage. A mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, or distribution of drugs and that collects, controls, and maintains transaction information. (3-21-12)

05. CDC. United States Department of Health and Human Services, Centers for Disease Control and Prevention. (3-21-12)

06. Central Pharmacy. A pharmacy within the state or a registered telepharmacy across state lines with which centralized pharmacy services have been contracted. (3-21-12)

07. Centralized Pharmacy Services. The processing by a pharmacy of a request from

another pharmacy to fill, refill, or dispense a prescription drug order or to perform processing functions such as prospective drug review. (3-21-12)

08. Change of Ownership. A change of majority ownership or controlling interest of a drug outlet licensed or registered by the Board. (3-21-12)

09. Charitable Clinic or Center -- Authorized Personnel. A person designated in writing and authorized by the qualifying charitable clinic or center's medical director or consultant pharmacist to perform specified duties within the charitable clinic or center under the supervision of a pharmacist, physician, dentist, optometrist, physician assistant, or an advanced practice professional nurse with prescriptive authority. (3-21-12)

10. Chart Order. A lawful drug order for a drug or device entered on the chart or a medical record of an inpatient or resident of an institutional facility. (3-21-12)

11. CME. Continuing medical education. (3-21-12)

12. COE -- Central Order Entry. A pharmacy that processes information related to the practice of pharmacy, engages solely in centralized prescription processing but from which drugs are not dispensed, is physically located outside the institutional pharmacy of a hospital, and is part of a hospital system. (3-21-12)

13. Collaborative Pharmacy Practice. A pharmacy practice whereby one (1) or more pharmacists jointly agree to work under a protocol authorized by one (1) or more prescribers to provide patient care and DTM services not otherwise permitted to be performed by a pharmacist under specified conditions or limitations. (3-21-12)

14. Collaborative Pharmacy Practice Agreement. A written agreement between one (1) or more pharmacists and one (1) or more prescribers that provides for collaborative pharmacy practice. (3-21-12)

15. Continuous Quality Improvement Program. A system of standards and procedures to identify and evaluate quality-related events and to constantly enhance the efficiency and effectiveness of the structures and processes of a pharmacy system. (3-21-12)

16. Correctional Facility. Any place used for the confinement of persons charged with or convicted of an offense or otherwise confined under a court order. ( )

16~~7~~7. CPE. Continuing pharmacy education. (3-21-12)

~~***17. CPEU**. Continuing pharmacy education unit.* (3-21-12)~~

18. DEA. United States Drug Enforcement Administration. (3-21-12)

19. Distributor. A supplier of drugs manufactured, produced, or prepared by others to persons other than the ultimate consumer. (3-21-12)

20. DME. Durable medical equipment. (3-21-12)

21. Drug Order. A prescription drug order issued in the unique form and manner permitted for a patient or resident of an institutional facility or as permitted for other purposes by these rules. Unless specifically differentiated, rules applicable to a prescription drug order are also applicable to a drug order. (3-21-12)

22. Drug Product Selection. The act of selecting either a brand name drug product or its therapeutically equivalent generic. (3-21-12)

23. Drug Product Substitution. Dispensing a drug product other than prescribed ~~*without the express permission of the prescriber and patient*~~. ~~*(3-21-12)*~~( )

24. DTM -- Drug Therapy Management. Selecting, initiating, or modifying drug treatment pursuant to a collaborative practice agreement. (3-21-12)

25. Emergency Drugs. Drugs required to meet the immediate therapeutic needs of one (1) or more patients that are not available from any other authorized source in sufficient time to avoid risk of harm due to the delay that would result from obtaining the drugs from another source. (3-21-12)

26. Executive Director. The Idaho State Board of Pharmacy executive director created by Sections 54-1713 and 54-1714, Idaho Code. (3-21-12)

27. FDA. United States Food and Drug Administration. (3-21-12)

28. Flavoring Agent. An additive used in food or drugs when the additive is used in accordance with the principles of good pharmacy practices and in the minimum quantity required to produce its intended effect. (3-21-12)

29. Floor Stock. Drugs or devices not labeled for a specific patient that are maintained at a nursing station or other department of an institutional facility, excluding the pharmacy, for the purpose of administering to patients of the facility. (3-21-12)

30. FPGEC. Foreign Pharmacy Graduate Examination Committee. ( )

3~~0~~**1. HIPAA**. Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). (3-21-12)

3~~1~~**2. Hospital System**. A hospital or hospitals and at least one (1) on-site institutional pharmacy under common ownership. A hospital system may also include one (1) or more COE pharmacies under common ownership. (3-21-12)

3~~2~~**3. Idaho State Board of Pharmacy or Idaho Board of Pharmacy**. The terms Idaho State Board of Pharmacy, Idaho Board of Pharmacy, State Board of Pharmacy, and Board of Pharmacy are deemed synonymous and are used interchangeably to describe the entity created under the authority of Title 54, Chapter 17, Idaho Code. Unless specifically differentiated, "the Board" or "Board" also means the Idaho State Board of Pharmacy. (3-21-12)

3~~3~~4. Individually Identifiable Health Information. Information that is a subset of health information, including demographic information, collected from an individual and that: (3-21-12)

a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (3-21-12)

b. Relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual that: (3-21-12)

i. Identifies the individual; or (3-21-12)

ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (3-21-12)

3~~4~~5. Institution Engaged in The Practice of Telepharmacy Across State Lines. An institutional facility engaged in the practice of telepharmacy into Idaho that is an out-of-state hospital with an institutional pharmacy licensed or registered in another state or a COE pharmacy licensed or registered in another state that is part of a hospital system. (3-21-12)

3~~5~~6. Institutional Pharmacy. A pharmacy located in an institutional facility. (3-21-12)

011. DEFINITIONS AND ABBREVIATIONS (J -- R).

01. LTCF -- Long-Term Care Facility. An institutional facility that provides extended health care to resident patients. (3-21-12)

02. MPJE. Multistate Pharmacy Jurisprudence Exam. (3-21-12)

03. MTM -- Medication Therapy Management. A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision or administration of a drug or a device and encompass a broad range of activities and responsibilities. The MTM service model in pharmacy practice includes the following five core elements: (3-21-12)

a. Medication therapy review; (3-21-12)

b. Personal medication record; (3-21-12)

c. Medication-related action plan; (3-21-12)

d. Intervention or referral, or both; (3-21-12)

e. Documentation and follow-up. (3-21-12)

04. NABP. National Association of Boards of Pharmacy. (3-21-12)

05. **NAPLEX**. North American Pharmacists Licensure Examination. (3-21-12)

06. **NDC**. National Drug Code. (3-21-12)

07. **Non-Institutional Pharmacy**. A pharmacy located in a drug outlet that is not an institutional facility. (3-21-12)

08. **Parenteral Admixture**. The preparation and labeling of sterile products intended for administration by injection. (3-21-12)

09. **Pharmaceutical Care Services**. A broad range of pharmacist-provided cognitive services, activities and responsibilities intended to optimize drug-related therapeutic outcomes for patients. Pharmaceutical care services may be performed independent of, or concurrently with, the dispensing or administration of a drug or device and encompasses services provided by way of DTM under a collaborative practice agreement, pharmacotherapy, clinical pharmacy practice, pharmacist independent practice, and MTM. Nothing in these rules allows a pharmacist, beyond what is statutorily allowed or allowed by a collaborative practice agreement, to diagnose, prescribe, order lab tests, or conduct complete physical exams. Pharmaceutical care services are not limited to, but may include one (1) or more of the following, according to the individual needs of the patient: (3-21-12)

a. Performing or obtaining necessary assessments of the patient's health status, including the performance of health screening activities that may include, but are not limited to, obtaining finger-stick blood samples; (3-21-12)

b. Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; (3-21-12)

c. Monitoring and evaluating the patient's response to drug therapy, including safety and effectiveness; (3-21-12)

d. Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; (3-21-12)

e. Documenting the care delivered; (3-21-12)

f. Communicating essential information or referring the patient when necessary or appropriate; (3-21-12)

g. Providing counseling education, information, support services, and resources applicable to a drug, disease state, or a related condition or designed to enhance patient compliance with therapeutic regimens; (3-21-12)

h. Conducting a drug therapy review consultation with the patient or caregiver; (3-21-12)

i. Preparing or providing information as part of a personal health record; (3-21-12)

j. Identifying processes to improve continuity of care and patient outcomes; (3-21-12)

k. Providing consultative drug-related intervention and referral services; (3-21-12)

l. Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; and (3-21-12)

m. Other services as allowed by law. (3-21-12)

10. Pharmacist Extern. A person enrolled in an accredited school or college of pharmacy who is pursuing a professional degree in pharmacy ~~*and is obtaining practical experience under the supervision of a pharmacist*~~. ~~*(3-21-12)*~~( )

11. Pharmacist Intern. A person who has successfully completed a course of study at an accredited school or college of pharmacy, has received a professional degree in pharmacy, and is obtaining practical experience under the supervision of a pharmacist. (3-21-12)

12. Pharmacy Operations. Activities related to and including the preparation, compounding, distributing, or dispensing of drugs or devices from a pharmacy. (3-21-12)

13. PHI -- Protected Health Information. Individually identifiable health information that is: (3-21-12)

a. Transmitted by electronic media (as defined by the HIPAA Privacy Rule at 45 CFR 160.103); (3-21-12)

b. Maintained in electronic media; and (3-21-12)

c. Transmitted or maintained in any other form or medium. (3-21-12)

d. PHI excludes individually identifiable health information in: (3-21-12)

i. Education records covered by the Family Education Right and Privacy Act, as amended (20 U.S.C. Section 1232g); (3-21-12)

ii. Records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv); and (3-21-12)

iii. Employment records held by a covered entity (as defined by the HIPAA Privacy Rule at 45 CFR 160.103) in its role as an employer. (3-21-12)

14. PIC. Pharmacist-in-charge. (3-21-12)

15. PMP. Prescription Monitoring Program. (3-21-12)

16. Prepackaging. The act of transferring a drug, manually or using an automated system, from a manufacturer's original container to another container prior to receiving a prescription drug order. (3-21-12)

17. Prescriber. An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. (3-21-12)

18. Prescriber Drug Outlet. A drug outlet in which prescription drugs or devices are dispensed directly to patients under the supervision of a prescriber, except where delivery is accomplished only through on-site administration or the provision of drug samples. (3-21-12)

19. Readily Retrievable. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-21-12)

20. Relative Contraindication. A condition that renders a particular treatment or procedure inadvisable, but not prohibitive. (3-21-12)

21. Remote Dispensing Site. A licensed pharmacy staffed by one or more certified technicians at which telepharmacy services are provided through a supervising pharmacy. (3-21-12)

22. Retail Non-Pharmacy Drug Outlet. A retail outlet that sells non-prescription drugs or devices that is not a pharmacy. (3-21-12)

23. Retail Pharmacy. A community or other pharmacy that sells prescription drugs at retail and is open to the public for business. (3-21-12)

24. R.N. Registered nurse. (3-21-12)

012. DEFINITIONS AND ABBREVIATIONS (S -- Z).

01. Sample. A unit of a drug that is not intended to be sold and is intended to promote the sale of the drug. (3-21-12)

02. Secured Pharmacy. The area of a drug outlet where prescription drugs are prepared, compounded, distributed, dispensed, or stored. (3-21-12)

03. Skilled Nursing Facility. An institutional facility or a distinct part of an institutional facility that is primarily engaged in providing daily skilled nursing care and related services. (3-21-12)

04. Student Pharmacist. A term inclusive of pharmacist intern and pharmacist extern if differentiation is not needed. (3-21-12)

05. Technician. Unless specifically differentiated, a term inclusive of pharmacy technician, certified pharmacy technician, and technician-in-training to indicate an individual authorized by registration with the Board to perform routine pharmacy support services under the supervision of a pharmacist. (3-21-12)

06. Telepharmacy. The use of telecommunications and information technologies in the practice of pharmacy to provide pharmaceutical care services to patients at a distance.

(3-21-12)

07. Therapeutic Equivalent Drugs. Products assigned an "A" code by the FDA in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) and animal drug products published in the FDA Approved Animal Drug Products (Green Book).
~~(3-21-12)~~( )

08. Unit Dose. Drugs packaged in individual, sealed doses with tamper-evident packaging (for example, single unit-of-use, blister packaging, unused injectable vials, and ampules). (3-21-12)

09. USP. United States Pharmacopeia. (3-21-12)

10. USP-NF. United State Pharmacopeia-National Formulary. (3-21-12)

11. VAWD -- Verified Accredited Wholesale Distributor. An accreditation program for wholesale distributors offered through NABP. (3-21-12)

12. VDO -- Veterinary Drug Outlet. A registered establishment that employs a qualified VDT to distribute prescription veterinary drugs pursuant to lawful orders of a veterinarian. (3-21-12)

13. VDT -- Veterinary Drug Technician. A non-pharmacist qualified by registration with the Board to distribute prescription veterinary drugs in a VDO. (3-21-12)

14. Veterinary Drug Order. A lawful order by a veterinarian issued pursuant to the establishment of a veterinarian-patient-client relationship as recognized by the American Veterinary Medical Association. (3-21-12)

15. VIS. Vaccine Information Statement. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

019. LICENSE AND REGISTRATION: ~~POSTING~~ INSPECTION.
Licenses and registrations issued under the Idaho Pharmacy and the Uniform Controlled Substances Acts must be ~~conspicuously posted~~ immediately retrievable at the licensed or registered location or at the drug outlet where the licensee or registrant is employed.
~~(3-21-12)~~( )

01. Application Pending. Pending receipt of the current registration or license from the Board, the confirmation of successful submission of an online application must be printed ~~and posted~~.
~~(3-21-12)~~( )

02. Temporary Locations. A licensee or registrant engaged in professional practice at a temporary or alternate location or in training must be able to produce written proof of licensure

or registration immediately upon request. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

031. PHARMACIST LICENSURE BY EXAMINATION: FOREIGN PHARMACY GRADUATES.

01. Licensure Submission Requirements. To be considered for licensure, a graduate of a school or college of pharmacy located outside of the United States must submit an application for licensure by examination, certification by the ~~*Foreign Pharmacy Graduate Examination Committee (*~~FPGEC~~*)*~~, and certification of completion of a minimum of fifteen hundred (1500) experiential hours. ~~*(3-21-12)*~~( )

02. Affidavit. An Idaho State Board of Pharmacy Employer's Affidavit certifying the experiential hours of a foreign pharmacy graduate must be signed by a pharmacist licensed and practicing in the United States and submitted to the Board. The Board may also request verifiable business records to document the hours. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

036. STUDENT PHARMACIST REGISTRATION.

01. Registration Requirements. ( )

a. To be approved for and maintain registration as a pharmacist extern, the applicant must currently be enrolled and in good standing in an accredited school or college of pharmacy, pursuing a professional degree in pharmacy. ( )

b. To be approved for and maintain registration as a pharmacist intern, the applicant must be: ( )

i. A graduate of an accredited school or college of pharmacy within the United States or; ( )

ii. A graduate of a school or college of pharmacy located outside the United States and obtain certification by the FPGEC. ( )

02. Renewal. ( )

a. ~~*Unless revoked or suspended by the Board, a*~~A pharmacist extern registration must be renewed annually ~~*on*~~ by July 15; however, the renewal fee will be waived for the duration of the ~~*extern's*~~ student's enrollment in the school or college of pharmacy and until July 15 following

graduation. ~~(3-21-12)~~( )

b. A pharmacist intern registration must be renewed annually by June 30. ( )

03. Cancellation of Registration. Failure to maintain the requirements for student pharmacist registration will result in the cancellation of registration. ( )

(BREAK IN CONTINUITY OF SECTIONS)

041. TECHNICIAN-IN-TRAINING REGISTRATION.
A person who has not obtained or maintained technician certification may apply for registration as a technician-in-training if the person satisfies all other requirements for registration as a technician and obtains and maintains employment as a technician-in-training. ~~(3-21-12)~~( )

01. Duties. Upon registration, a technician-in-training may perform any of the duties allowed by statute or rule to be delegated to a registered technician under the supervision of a pharmacist. (3-21-12)

02. Renewal. The registration of a technician-in-training ~~expires on~~ must be renewed by June 30, ~~and~~ but is only renewable two (2) times. ~~(3-21-12)~~( )

03. Registration Expiration. Upon the final expiration of a technician-in-training registration, a person must satisfy the technician certification and registration requirements of these rules to be lawfully employed as, or otherwise perform the duties of, a technician. (3-21-12)

04. Cancellation of Registration. Failure to maintain employment will result in the cancellation of the registration. ( )

042. PHARMACY TECHNICIAN CERTIFICATION: CONTINUOUS EMPLOYMENT EXEMPTION.
A technician registered with the Board and employed as a technician on June 30, 2009, is not required to obtain or maintain certification as a condition of registration renewal after June 30, 2009, as long as the registrant remains continuously employed as a technician by the same employer. If a registrant that qualifies for this exemption disrupts continuous employment as a technician with one employer, the technician registration will ~~correspondingly terminate on the date of employment termination~~ become invalid. The person must thereafter satisfy the certified pharmacy technician registration requirements of these rules to be lawfully employed as, or otherwise perform the duties of, a technician. ~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

131. DRUG PRODUCT: SELECTION.

Drug product selection is allowed only between therapeutic equivalent drugs. (3-21-12)

01. ~~Method of~~ Brand Name Drug ~~Product Selection~~ Dispensing. If ~~A~~a ~~branded product must be dispensed only if "BRAND ONLY" is specified by the~~ prescriber ~~on the electronic prescription~~ orders by any means that a brand name drug ~~order or on the face of a paper prescription~~ must be dispensed, then no drug ~~order by a "BRAND ONLY" check box or a handwritten notation~~ selection is permitted. ~~(3-21-12)~~( )

02. ~~Drug Product Selection~~ Documentation. If a generic is selected by a non-institutional pharmacy, the name of the drug and the manufacturer or the NDC number must be documented in the patient medication record. ~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

140. STANDARD PRESCRIPTION DRUG LABELING.
Unless otherwise directed by these rules, a prescription drug must be dispensed in an appropriate container that bears the following information: (3-21-12)

01. Dispenser Information. The name, address, and telephone number of the dispenser (person or business); (3-21-12)

02. ~~Prescription~~ Serial Number. The ~~prescription~~ serial number; ~~(3-21-12)~~( )

03. Date. The date the prescription is filled; (3-21-12)

04. Prescriber. The name of the prescriber; (3-21-12)

05. Patient. The name of the patient, and if the patient is an animal, the species; (3-21-12)

06. Drug Name and Strength. Unless otherwise directed by the prescriber, the name and strength of the drug (the generic name and its manufacturer's name or the brand name); (3-21-12)

07. Quantity. The quantity of item dispensed; (3-21-12)

08. Directions. The directions for use; (3-21-12)

09. Cautionary Information. Cautionary information as required or deemed appropriate for proper use and patient safety; (3-21-12)

10. Expiration. An expiration date that is the lesser of: (3-21-12)

a. One (1) year from the date of dispensing; (3-21-12)

b. The manufacturer's original expiration date; (3-21-12)

c. The appropriate expiration date for a reconstituted suspension or beyond use date for a compounded product; or (3-21-12)

d. A shorter period if warranted; (3-21-12)

11. Refills. The number of refills remaining, if any, or the last date through which the prescription is refillable; and (3-21-12)

12. Warning. The warning: "Caution: State or federal law, or both, prohibits the transfer of this drug to any person other than the patient for whom it was prescribed." (3-21-12)

13. Pharmacist Identification. The initials or other unique identifier of the dispensing pharmacist. ( )

(BREAK IN CONTINUITY OF SECTIONS)

142. PARENTERAL ADMIXTURE LABELING.
If one or more drugs are added to a parenteral admixture the admixture's container must include a distinctive, supplementary label with at least the following information: (3-21-12)

01. Ingredient Information. The name, amount, strength, and if applicable, the concentration of the drug additive and the base solution or diluent; (3-21-12)

02. Date and Time. The date and time of the addition, or alternatively, the beyond use date and time;
(3-21-12)

03. ~~*Preparer*~~ Identification. The initials or other unique identifier of the ~~*person who added the drug or drugs*~~ pharmacist or preparing prescriber responsible for its accuracy;
~~*(3-21-12)*~~( )

04. Prescribed Administration Regimen. The rate or appropriate route of administration or both, as applicable; and (3-21-12)

05. Special Instructions. Any special handling, storage, or device-specific instructions. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

200. CONTROLLED SUBSTANCES: POSITIVE IDENTIFICATION REQUIRED.

A potential recipient of a controlled substance must first be positively identified or the controlled substance must not be dispensed. (3-21-12)

01. Positive Identification Presumed. Positive identification is presumed and presentation of identification is not required if dispensing directly to the patient and if: (3-21-12)

a. The controlled substance will be paid for, in whole or in part, by an insurer; or (3-21-12)

b. The ~~*dispenser is part of the institutional facility where the*~~ patient is being treated at an institutional facility or is housed in a correctional facility. ~~*(3-21-12)*~~( )

c. The filled prescription is delivered to the patient's residence either by mail, common carrier, or an employee of the pharmacy. ( )

02. Personal Identification. Presentation of identification is also not required if the individual receiving the controlled substance is personally and positively known by a pharmacy or prescriber drug outlet staff member who is present and identifies the individual and the personal identification is documented by recording: (3-21-12)

a. The recipient's name (if other than the patient); (3-21-12)

b. A notation indicating that the recipient was known to the staff member; and (3-21-12)

c. The identity of the staff member making the personal identification. (3-21-12)

03. Acceptable Identification. The identification presented must include an unaltered photograph and signature and acceptable forms include a valid state or military driver's license or identification card and a valid passport. (3-21-12)

04. Identification Documentation. Documentation of the recipient's identification must be permanently linked to the record of the dispensed controlled substance and must include: (3-21-12)

a. A copy of the identification presented; or (3-21-12)

b. A record that includes: (3-21-12)

i. The recipient's name; (3-21-12)

ii. A notation of the type of identification presented; (3-21-12)

iii. The state, military branch, or other government entity that issued the identification; and (3-21-12)

iv. The identification number of the driver's license, identification card, or passport. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

206. CONTROLLED SUBSTANCES: INVENTORIES.

01. Annual Inventory of Stocks of Controlled Substances. Each registrant must conduct an inventory of controlled substances on hand ~~*at least every twelve (12) months*~~ annually within seven (7) days of the date of the prior year's inventory in a form and manner that satisfies the inventory requirements of federal law. ~~*(3-21-12)*~~( )

02. Separate Inventories for Each Location. A separate controlled substances inventory must be taken and retained at each registered location. (3-21-12)

03. Inventory on PIC or Director Change. A complete controlled substance inventory must be conducted in the event of a change of PIC ~~*change*~~ or director on or by the first day of employment of the incoming PIC or director. ~~*(3-21-12)*~~( )

04. Inventory After Discovery of Theft or Loss. A complete controlled substance inventory must be conducted within forty-eight (48) hours of the discovery of a theft or reportable loss of a controlled substance. (3-21-12)

05. Inventory on Addition to Schedule of Controlled Substances. On the effective date of an addition of a substance to a schedule of controlled substances, each registrant that possesses that substance must take an inventory of the substance on hand, and thereafter, include the substance in each inventory. (3-21-12)

06. Annual Inventory Compliance. Complete inventories conducted as otherwise required by these rules may also be considered in complying with the annual inventory requirement. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

260. DRUG PRODUCT STORAGE.

~~*Prescription d*~~Drugs~~*, controlled substances, or other items restricted to sale, dispensing, or administration by, or under the supervision of, a pharmacist or other registrant*~~ must be stored in accordance with USP-NF requirements in an area maintained and secured appropriately to safeguard product integrity and protect against product theft or diversion. ~~*(3-21-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

262. RESTRICTED RETURN OF DRUGS OR DEVICES.
Once removed from the premises from which it was dispensed, a drug or prescription device must only be accepted for return under the conditions permitted by this rule or pursuant to the Legend Drug Donation Act and rules. (3-21-12)

01. Qualifying Returns. Unless dispensed in any manner inconsistent with the prescriber's instructions and returned for quarantine for destruction purposes only, a drug or prescription device that has been received from or delivered to the patient or the patient's representative is ineligible for return. Drugs or devices that may qualify for return include: (3-21-12)

a. Those intended for inpatients of an institutional facility that have been maintained in the custody and control of the institutional facility or dispensing pharmacy; and (3-21-12)

b. That are liquid or in unit dose or unit-of-use packaging and, if a controlled substance, returned from a hospital daily delivery system; and (3-21-12)

c. Those for which the following conditions are satisfied: (3-21-12)

i. The drug was delivered by the dispensing pharmacy directly to the institutional facility or its authorized agent and subsequently stored in a suitable drug storage area that is inaccessible to patients; (3-21-12)

ii. The drug is returned in an unopened manufacturer-sealed container or with other tamper-evident packaging intact; (3-21-12)

iii. In the professional judgment of the pharmacist, the safety and efficacy of the drug has not been compromised; and (3-21-12)

iv. A system is in place to track the restocked drug for purposes of a recall. (3-21-12)

02. Marking Ineligible Returns. Drugs or devices otherwise eligible for return that are or will become ineligible for any reason must be clearly marked "Not Eligible for Return" prior to leaving the institutional facility or upon discovery and before storing in an area with other eligible returns. (3-21-12)

03. Consulting Pharmacy and PIC Responsibilities. The pharmacy and its PIC are responsible for: ( )

a. C~~c~~onsulting with an institutional facility from which returns will be accepted; ~~*and must ensure*~~ ( )

b. Ensuring that the institutional facility has an employee trained and knowledgeable in the proper storage, use, and administration of drugs and devices; ~~*at the institutional facility. (3-21-12)*~~( )

c. Reviewing, approving, and enforcing written protocols that will ensure compliance with the conditions necessary to allow returns; and ( )

d. Storing a copy of the protocols, as well as the written approval thereof, in an immediately retrievable fashion. ( )

(BREAK IN CONTINUITY OF SECTIONS)

503. PRESCRIPTION DELIVERY RESTRICTIONS.
A pharmacist must not participate in any arrangement or agreement whereby filled prescriptions may be left at, picked up from, accepted by, or delivered to any place of business not registered as a pharmacy except that a pharmacist or a pharmacy, by means of its agent, may deliver filled prescriptions to the patient, the patient's residence, the hospital or other institutional facility in which the patient is convalescing, the correctional facility in which a patient is housed, or if a non-controlled substance, to the patient's licensed or registered healthcare provider.
~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

600. PHARMACY REGISTRANT AND PIC OR DIRECTOR.

01. Designated PIC or Director Required. A new pharmacy must have a designated PIC or director by the date of opening and must not ~~*be without*~~ thereafter allow a vacancy or lapse in appointment of a designated PIC or director to continue for more than thirty (30) sequential days. ~~(3-21-12)~~( )

02. Corresponding and Individual Responsibility. The pharmacy registrant and the PIC or director each have corresponding and individual responsibility for compliance with the law and these rules in all aspects of the sale and the dispensing of drugs, devices, and other materials at the drug outlet, including the safe, accurate, secure, and confidential handling and storage and the preparation, compounding, distributing, or dispensing of drugs and PHI.
(3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

602. PHARMACY TECHNICAL EQUIPMENT.

01. Technical Equipment. A pharmacy must have appropriate technical equipment to maintain the electronic recordkeeping requirements of these rules and any additional equipment and supplies required by its scope of practice to ensure public safety. (3-21-12)

02. PHI Transmission Equipment Location. A non-institutional pharmacy that uses

a fax machine or other equipment to electronically send or receive PHI must locate and maintain the equipment within the secured pharmacy. (3-21-12)

03. Separate Telephone. ~~*A pharmacy*~~ Pharmacies remodeled or constructed after the effective date of this rule must have a separate and distinct telephone line from that of the business that must not be answerable by non-pharmacy personnel. If a pharmacy uses an automatic answering system, messages must not be retrieved or pharmacy services performed by non-pharmacy personnel. ~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

605. PHARMACY SECURITY.

01. Basic Security Standards. A pharmacy must be constructed and equipped with adequate security, and at least while closed, utilize an alarm or other comparable monitoring system to protect its equipment, records, and supply of drugs, devices, and other restricted sale items from unauthorized access, acquisition, or use. Pharmacies without an alarm or other monitoring system as of the effective date of this rule must comply with this rule upon completion of a structural remodel. (3-21-12)

02. Non-Institutional Pharmacy Security During Pharmacist Absence. A non-institutional pharmacy must be closed for business and secured during all times a pharmacist is not present except: ( )

a. ~~*for*~~ If a technician or student pharmacist is on to duty, to allow brief pharmacist absences within the business establishment; or ( )

b. ~~*t*~~To perform professional services in the peripheral areas immediately outside of the pharmacy. ~~(3-21-12)~~( )

03. Structural Security Requirements. If a pharmacy is located within an establishment that is open to the public for business at times when a pharmacist is not present, the pharmacy must be totally enclosed in a manner sufficient to provide adequate security for the pharmacy, as required by this rule and approved by the Board. (3-21-12)

a. Pharmacy walls must extend to the roof or the pharmacy must be similarly secured from unauthorized entry. (3-21-12)

b. Solid core or metal doors are required for new or remodeled pharmacies after the effective date of this rule. ~~(3-21-12)~~( )

c. Doors and other access points must be constructed in a manner that the hinge hardware is accessible only from inside of the pharmacy and must be equipped with locking devices. (3-21-12)

d. If used, a "drop box" or "mail slot" allowing delivery of prescription drug orders to the pharmacy during hours closed must be appropriately secured against theft, and the pharmacy hours must be prominently visible to the person depositing the prescription drug order. Prescriptions must not be accepted for delivery to the pharmacy or for depositing in the drop box by non-pharmacy employees of a retail establishment. (3-21-12)

04. Restricted Access to the Pharmacy. No one must be allowed entrance to the closed and secured pharmacy unless under the direct supervision of a pharmacist or except as permitted by these rules for an institutional pharmacy. (3-21-12)

606. PHARMACY NOTIFICATION AND ADVERTISING OF HOURS OPEN FOR BUSINESS.

01. Notification of Business Hours. A pharmacy must notify the Board and prominently display the hours open to the public for business, if applicable, on or adjacent to its entrance and the entrance of the business establishment in which it is located if the open hours are different. (3-21-12)

02. Notification of Change of Business Hours. The Board and the public must be notified of changes to the hours that a pharmacy is open to the public for business, including changes resulting in differential hours, at least seven (7) days prior to the change except changes of hours in recognition of state holidays set forth in Section 73-108, Idaho Code. A change of hours for a holiday must be prominently posted for public notice at least seven (7) days in advance. ~~(3-21-12)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

609. PHARMACY CHANGE OF OWNERSHIP OR PERMANENT CLOSING.

01. Board Notification. The registrant must notify the Board of a pharmacy's change of ownership or permanent closure at least ten (10) days prior to the event. The notice must include: (3-21-12)

a. The name and address of the pharmacy to be sold or closed; (3-21-12)

b. The date of sale or closure; (3-21-12)

c. The name and address of the business acquiring the prescription inventory; and (3-21-12)

d. The name and address of the pharmacy acquiring the prescription files and patient profiles in compliance with the records retention requirement. (3-21-12)

02. Public Notice. A registrant must notify the general public of the pharmacy's permanent closing at least ten (10) days prior to closing. The notice must include the date of

closure and the new location of the prescription files. Notice must be provided by prominent posting in a public area of the pharmacy. (3-21-12)

03. Pharmacy Signs. Unless sold and transferred to another pharmacy operator, a registrant must remove or completely cover each sign and other exterior indication that the premises was a pharmacy within thirty (30) days after the date a pharmacy permanently ceases operations. (3-21-12)

04. Transfer or Other Disposition of Drugs and Prescription Files. The PIC of a pharmacy that ceases operation must: ( )

a. ~~a~~Adequately secure and protect the prescription files from unlawful use or disclosure; ( )

b. Secure and protect the drug product inventory from diversion, deterioration, or other damage until lawful transfer or disposition; and ~~must~~ ( )

c. ~~r~~Retain a closing inventory of controlled substances. ~~(3-21-12)~~( )

05. Pharmacy Change of Ownership. A change of ownership of a currently registered pharmacy will require the submission and approval of a new pharmacy registration application but will not require an onsite inspection prior to issuance of a pharmacy registration unless structural remodeling occurs. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

622. INSTITUTIONAL PHARMACY: DIRECTOR: MINIMUM RESPONSIBILITIES. Each institutional pharmacy must be supervised and directed by an Idaho-licensed pharmacist (referred to herein as "the director") who is knowledgeable in, and thoroughly familiar with, the specialized functions of institutional pharmacies. The director is responsible for ensuring compliance with applicable law and for each activity of the institutional pharmacy, including at least the following: (3-21-12)

01. Policies and Procedures. In coordination with the appropriate institutional facility personnel, the adoption of policies and procedures with sufficient specificity regarding the handling, storage, and dispensing of drugs within the institution to protect public health and safety and ensure compliance with these rules and other applicable law. (3-21-12)

02. Formulary or Drug List Development. The participation in any development of a formulary or drug list for the facility. (3-21-12)

03. Product Procurement. The procurement of drugs, chemicals, biologicals, devices, or other products used by the institutional facility for patient pharmaceutical care services or for which a drug order is required. (3-21-12)

04. Drug Use, Storage, and Accountability. The safe and efficient dispensing, distribution, control, and secured storage of, and accountability for, drugs within the facility, including at least the following: (3-21-12)

a. Ensuring that drugs stored within the institutional pharmacy or in alternative secured storage areas have proper sanitation, temperature, light, ventilation, moisture control, segregation and security; (3-21-12)

b. Ensuring that outdated or other unusable drugs are identified and stored in a manner that prevents their distribution or administration prior to disposition; (3-21-12)

c. Ensuring that emergency drugs are in adequate and proper supply at designated locations; (3-21-12)

d. Ensuring that requirements applicable to the purchasing, storing, distribution, dispensing, recordkeeping, and disposal of controlled substances are met throughout the institution, including but not limited to, ensuring that controlled substances stored in surgery or emergency departments, nursing stations, ambulatory clinics, diagnostic laboratories or other locations outside of the pharmacy are inaccessible to unauthorized personnel; (3-21-12)

e. Ensuring accurate filling and labeling of containers from which drugs are to be administered or dispensed; (3-21-12)

f. Ensuring appropriate admixture of parenteral products, including serving in an advisory capacity for nursing personnel concerning incompatibility and the provision of proper incompatibility information; and (3-21-12)

g. Ensuring appropriate provision and maintenance, in both the pharmacy and patient care areas, of a sufficient inventory of antidotes and other emergency drugs, current antidote information, telephone numbers of regional poison control centers and other emergency assistance organizations, and other materials and information determined necessary by the appropriate institutional facility personnel. (3-21-12)

05. Emergency Drug Access Protocol. In coordination with the appropriate institutional facility personnel, the development of an emergency drug access protocol and related training of R.N.s to ensure appropriate knowledge of the proper methods of access, removal of drugs, documentation, and other required procedures prior to the R.N.'s designation for access to emergency drug supplies. (3-21-12)

06. Suspected Adverse Drug Reaction Reporting. The reporting in a timely manner of a suspected adverse drug reaction to the ordering physician and to the appropriate institutional facility personnel. The director may use discretion and, if deemed necessary or advisable for public health or safety, report a suspected reaction to others such as MedWatch, the manufacturer, and the USP. (3-21-12)

07. Records Maintenance. The maintenance of records of institutional pharmacy transactions required by law. (3-21-12)

08. Teaching, Research, and Patient Care Evaluation Programs. The cooperation with any teaching and research programs and the participation in any patient care evaluation programs relating to pharmaceutical utilization and effectiveness within the institutional facility. (3-21-12)

09. Continuous Quality Improvement Program. The development and implementation of a continuous quality improvement program to review and evaluate pharmaceutical services and recommend improvements. (3-21-12)

10. Director Change. Both an outgoing and incoming director must report to the Board a change in the institutional pharmacy director within ten (10) days of the change. ( )

(BREAK IN CONTINUITY OF SECTIONS)

637. INSTITUTIONAL FACILITY: EMERGENCY OUTPATIENT DRUG DELIVERY BY HOSPITAL EMERGENCY ROOMS.

~~*A limited supply of d*~~Drugs~~*, not including Schedule II controlled substances,*~~ may be ~~*approved for delivery*~~ delivered by an RN to outpatients ~~*receiving*~~ being treated in a hospital emergency room ~~*treatment if stored in the emergency room pursuant to applicable law and these rules pertaining to emergency drug product storage and if accessed and delivered as permitted or restricted by this rule.*~~ as follows: ~~*(3-21-12)*~~( )

01. Prerequisites: ( )

a. In the presence of a prescriber, acting as an agent of that prescriber, or outside the presence of a prescriber, when there is no prescriber present in the hospital in accordance with applicable state and federal law; ( )

b. Pursuant to a valid drug order issued by a prescriber; ( )

c. When no pharmacist is on duty in the community; and ( )

d. When drugs are stored and accessed in accordance with applicable laws and rules. ( )

0~~1~~2. Limitations. No more than one (1) prepackaged container of the same drug may be delivered unless more than one (1) package is required to sustain the patient until the first available pharmacist is on duty in the community except that the full course of therapy for anti-infective medications may be provided. (3-21-12)

0~~2~~3. Documentation. Delivery ~~*must occur only pursuant to a valid drug order and*~~ must be documented as required by these rules for institutional facility emergency drug access. ~~*(3-21-12)*~~( )

0~~3~~4. Labeling. The institutional pharmacy must prepackage and affix ~~*A*~~a label ~~*must be*~~

~~affixed~~ to the container with the information required by ~~these~~ the standard prescription drug labeling rules, except that blank spaces may be left for ~~outpatient dispensing~~ the names of the patient and prescriber and directions for use. ~~(3-21-12)~~( )

~~**04. R.N. Staff Personnel Only**. This rule does not authorize any person other than an R.N. on a hospital's emergency room staff to prepare or deliver prescription drugs to outpatients receiving emergency treatment.~~ ~~(3-21-12)~~

(BREAK IN CONTINUITY OF SECTIONS)

713. -- 7~~4~~29. (RESERVED)

730. OUT-OF-STATE MAIL SERVICE PHARMACY.
An out-of-state mail service pharmacy, during its regular hours of operation, but no less than forty (40) hours in six (6) days per week, provide a toll-free telephone service to facilitate communication between Idaho patients and a pharmacist with access to the patient records. This toll-free number must be disclosed on the prescription label for drugs dispensed to Idaho patients. ( )

731. -- 749. (RESERVED)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1203

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

A detailed summary of the reason for adopting this rulemaking is set forth in the initial proposed rulemaking. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 653 through 659**. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin.

The Board of Pharmacy received public comment regarding access control for ADS systems and "authorized designee" that is being added in Paragraph 290.03.a.; professionals with authority to replenish the ADS systems and "nurse" which is being added in Subsection 290.05; the physical location of ADS systems in hospitals, pharmacies and prescriber drug outlets and language that is being deleted for clarification, but no substantive changes are being made in Subparagraph 291.01.b.i.; drug returns to ADS systems in hospitals and an exemption is being created for hospital ADS systems in Subsection 292.03; and vending machines and a grammatical revision that is being made replacing "and" with "which" in Section 293.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

DATED this 30th day of November, 2012.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to 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 October 17, 2012.

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:

As requested by a rural, Idaho hospital to improve patient safety. This rulemaking docket would expand the use of self-service automated dispensing and storage systems (ADS) to hospital emergency rooms (ER).

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012 Idaho Administrative Bulletin, **Vol. 12-5, Page 82**, and in the August 1, 2012 Idaho Administrative Bulletin, **Vol. 12-8, page 73**, Docket No. 27-0101-1201.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

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 October 24, 2012.

DATED this 7th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1203

290. ADS SYSTEMS: MINIMUM STANDARDS.
This rule establishes the minimum standards for the use of an ADS system to dispense and store drugs and devices. (3-21-12)

01. System Registration and Approved Utilization Locations. One or more ADS systems may be utilized by the following drug outlets if registered as required by the Board: (3-21-12)

a. In a pharmacy, remote dispensing site, or other ambulatory healthcare setting where utilization of the ADS system is under the adequate personal or electronic supervision of a pharmacist, as defined by these rules; (3-21-12)

b. In a prescriber drug outlet; and (3-21-12)

c. In an institutional facility. (3-21-12)

02. Multiple System Documentation. At least the following documentation must be maintained for each ADS system by the supervising pharmacy or prescriber drug outlet utilizing multiple ADS systems: (3-21-12)

a. The manufacturer's name and model of the ADS system; (3-21-12)

b. The state and, if applicable, federal ADS system registrations; and (3-21-12)

c. The name, address, and specific location where the ADS system is operational. (3-21-12)

03. System Access, Monitoring, and Control. Access to the ADS system must be

monitored and controlled as follows: (3-21-12)

a. Proper identification controls, including electronic passwords or other coded identification, must be utilized and access control must be limited and authorized by the prescriber, PIC, ~~or~~ director *or their authorized designee*; ~~(3-21-12)~~*( )*

b. The prescriber, PIC, or director must be able to stop or change access at any time; (3-21-12)

c. The prescriber, PIC, or director must maintain a current and immediately retrievable list of persons who have access and the limits of that access; (3-21-12)

d. Review of user access reports must be conducted periodically to ensure that access by persons no longer employed has been appropriately disabled; and (3-21-12)

e. Access for maintenance or repair must be pre-approved by the prescriber, PIC, or director and must be performed under the continuous supervision of a person with appropriate access authorization. (3-21-12)

04. System Security and Patient Confidentiality. The ADS system must have adequate system security and safeguards to prevent and detect unauthorized access or use, maintain the integrity of patient records and prescription drug orders, and protect patient privacy. (3-21-12)

05. System Filling, Stocking, Replenishing. The filling, stocking, or replenishing of drugs into the ADS system must be accomplished by a pharmacist, technician, prescriber, *nurse* or authorized prescriber drug outlet personnel. Timely pharmacist or prescriber verification of the accuracy of the filling, stocking, or replenishing of the ADS system must occur through a manual process, bar coding, or other electronic technology used for item identification. ~~(3-21-12)~~*( )*

06. Stocked Drug Documentation. The ADS system must be able to generate a record on demand of drugs filled into the system that includes at least: (3-21-12)

a. The date; (3-21-12)

b. The drug name; (3-21-12)

c. The dosage form; (3-21-12)

d. The strength; (3-21-12)

e. The quantity; (3-21-12)

f. The drug expiration; (3-21-12)

g. The identity of the ADS system; and (3-21-12)

h. The name or initials of the authorized individual filling the ADS system and, if

applicable, the verifying pharmacist or prescriber. (3-21-12)

07. System Access and Transaction Documentation. The ADS system must automatically document transactions and other events involving access to system contents that is immediately retrievable in written or electronic form and includes at least the following: (3-21-12)

a. The identity of the system and, if applicable, the component accessed; (3-21-12)

b. The name or other identification (e.g., electronic signature or unique identifier) of the person conducting the transaction; (3-21-12)

c. The type of transaction; (3-21-12)

d. The date and time of transaction; (3-21-12)

e. The name, strength, dosage form, and quantity of the drug or description of the medical device accessed; and (3-21-12)

f. If applicable, the name of the patient for whom the drug was ordered. (3-21-12)

~~***08. Supervising Pharmacy Documentation**. The supervising pharmacy of a remote dispensing site must retain separate records of transactions and prescriptions processed by each ADS system utilized.* (3-21-12)~~

0~~9~~8. ADS System Used for Tablets or Capsules. The lot number of each drug contained in an ADS system used to store in bulk and to count tablets or capsules for dispensing must be retained in an immediately retrievable manner or posted on the device. (3-21-12)

~~1~~09. Prepackaged Bulk Drug Cartridges or Containers. If the ADS system uses removable cartridges or containers to hold bulk drugs, the prepackaging of the cartridges or containers must occur at the pharmacy where the original inventory is maintained unless provided by an FDA-approved repackager that is licensed as a wholesaler. The prepackaged cartridges or containers may be sent to a remote dispensing site to be loaded into the ADS system by a pharmacist or a technician if: (3-21-12)

a. A pharmacist has verified the proper filling and labeling of the cartridge or container; (3-21-12)

b. The individual cartridges or containers are transported to the ADS system in a secure, tamper-evident container; and (3-21-12)

c. The ADS system utilizes technologies to ensure that the cartridges or containers are accurately loaded. (3-21-12)

1~~1~~0. ~~*Self-Service ADS System*~~ Temperature Sensitive Drugs. ~~*An ADS system may be used for self-service delivery of prescriptions if in compliance with this rule.* (3-21-12)~~

~~**a.**~~ Products that are temperature sensitive must not be provided unless the system is able to maintain required storage conditions. ~~(3-21-12)~~( )

~~**b.** *Controlled substances and products that require additional preparation to be ready for patient use must not be provided.* (3-21-12)~~

~~**c.** *The system must be physically attached to the pharmacy or prescriber drug outlet in a manner that access to areas used to stock the device are only accessible through the pharmacy or prescriber drug outlet by authorized personnel.* (3-21-12)~~

~~**d.** *The system must be operational only during the operating hours of the pharmacy or prescriber drug outlet.* (3-21-12)~~

~~**e.** *A self-service ADS system must not be used to deliver new prescriptions outside of a prescriber drug outlet.* (3-21-12)~~

~~**f.** *Prescribers utilizing a self-service ADS system to deliver new prescriptions must provide patient counseling on all new medications.* (3-21-12)~~

~~**g.** *The use of a self-service ADS system for prescription refills must comply with laws applicable to the provision of refills by a pharmacy and must provide a patient notification with information about how counseling may be obtained.* (3-21-12)~~

~~**12. Vending Machines**. *Only non-prescription medical supplies and drugs that are unrestricted for over-the-counter sale may be stored and sold in vending machines and are subject to inspection by the Board upon reasonable notice.* (3-21-12)~~

291. ADS SYSTEMS: SELF-SERVICE SYSTEMS.
The use of self-service ADS systems must comply with the ADS system minimum standards and the requirements of this rule. ( )

01. System Requirements. ( )

a. The system must only be operational: ( )

i. During the operating hours of the pharmacy, or prescriber drug outlet respectively; or ( )

ii. In a hospital's emergency room if no pharmacist is on duty in the community. ( )

b. The system must be substantially constructed, utilize adequate security, and be: ( )

i. Physically attached or immediately adjacent to the interior of the pharmacy in a manner that access to areas used to stock the device are only accessible through the pharmacy; or ( )

ii. Located within the hospital's emergency room or prescriber drug outlet. ( )

02. Dispensing Restrictions. ( )

a. Products requiring additional preparation for patient use must be dispensed by the system directly to a prescriber or registered nurse for subsequent preparation and not dispensed directly to the patient. ( )

b. A pharmacy system may only dispense drugs or devices that have been previously dispensed to the patient. ( )

c. Controlled substances are prohibited in a pharmacy or prescriber drug outlet system. ( )

d. Drugs must be prepackaged for use in hospital emergency room systems and no more than one (1) prepackaged container of the same drug may be delivered unless more than one (1) package is required to sustain the patient until the first available pharmacist is on duty in the community except that the full course of therapy for anti-infective medications may be provided. ( )

e. Hospital emergency room systems must only dispense to hospital emergency room patients. ( )

f. Hospital emergency room systems vouchers or their equivalent must expire within twenty-four (24) hours. ( )

03. Counseling. ( )

a. When dispensed via a system in a prescriber drug outlet or a hospital's emergency room, a patient must receive counseling prior to receiving drugs or devices that have not been previously dispensed to the patient. ( )

b. Refilled or renewed drugs dispensed via a system must include written notification of how counseling may be obtained. ( )

04. Packaging and Labeling. Drugs dispensed via a system must be compliant with the standard prescription drug labeling rule, the prescription drug packaging rule, and other pertinent rules. ( )

29~~1~~2. ADS SYSTEMS: INSTITUTIONAL FACILITIES.
Institutional facilities utilizing one or more ADS systems must ensure compliance with the ADS system minimum standards~~, as applicable,~~ and the requirements of this rule. ~~(3-21-12)~~( )

01. Product Packaging and Labeling. Except as provided herein, drugs stored in the ADS system must be contained in the manufacturers' sealed, original packages or in prepackaged unit-of-use containers (e.g., unit dose tablet/capsule, tube of ointment, inhaler, etc.) and must be labeled as required by these rules. Exceptions to these packaging requirements include: (3-21-12)

a. Injectable drugs stored in a multi-dose vial (e.g., heparin) from which the drug may be withdrawn into a syringe or other delivery device for single patient use; or (3-21-12)

b. OTC products stored in a manufacturers' sealed, multi-dose container (e.g., antacids, analgesics) from which the drug may be withdrawn and placed into an appropriate container for single patient use. (3-21-12)

02. Pharmacist Review. A pharmacist must review the drug order prior to any removal from the system of a drug intended for immediate patient administration except if: (3-21-12)

a. The system is being used as an after-hours cabinet for drug dispensing in the absence of a pharmacist; (3-21-12)

b. The system is being used in place of an emergency kit; (3-21-12)

c. The system is being used to provide access to emergency drugs and only a quantity sufficient is removed to meet the immediate need of the patient; (3-21-12)

d. The drug is a subsequent dose from a previously reviewed drug order~~. *Any change made to the drug order requires a new approval by a pharmacist prior to removing the drug.*~~; or ~~*(3-21-12)*~~( )

e. The prescriber controls the drug administration process in procedural areas. ( )

03. ~~*Product*~~ Drug Returns. The ADS system, *except a self-service system used in a hospital's emergency room,* must provide a mechanism for securing and accounting for drugs removed from and subsequently returned to the system ~~*(e.g., a return bin)*~~. ~~*(3-21-12)*~~( )

~~*a.*~~ A drug removed from a system but not administered to a patient ~~*must*~~ may be returned ~~*to the pharmacy immediately or maintained in a manner that prevents access to*~~ as follows if unopened, sealed, intact and stored in compliance with the ~~*returned*~~ drug ~~*except*~~ product storage rule to~~ *return it to the pharmacy and except*~~: ~~*(3-21-12)*~~( )

a. The pharmacy, immediately; ( )

b. The ADS system for immediate reuse by authorized personnel in hospitals utilizing bar code scanning technology at the bedside or the ADS system; ( )

c. The ADS return bin, until: ( )

i. Returned to the pharmacy; or ( )

ii. Returned to the ADS system; or ( )

d. An alternative, secure storage area until return to the pharmacy or the ADS is feasible only if the drug: ( )

i. ~~Items that are~~ Is too large or bulky to be inserted into the system's return bin; ~~(3-21-12)~~( )

ii. ~~Items r~~Requir~~ing~~es refrigeration; or ~~(3-21-12)~~( )

iii. Requires immediate accessibility for ~~L~~limited critical ~~care items for which inaccessibility would compromise~~ patient care. ~~(3-21-12)~~( )

~~**b.** A removed drug or device must not be returned directly to the system for immediate reissue or reuse. (3-21-12)~~

~~**c.** Once removed, a drug or device must not be reused or reissued except: (3-21-12)~~

~~i. Drugs stored after dispensing under the drug storage conditions required by these rules; (3-21-12)~~

~~ii. As supervised by the pharmacist; and (3-21-12)~~

~~iii. In unopened, sealed, intact, and unaltered containers. (3-21-12)~~

04. Wasted ~~and Discarded Drugs~~ Controlled Substances. If wasted before completing the transaction, ~~T~~the *~~ADS~~* system must provide a mechanism for ~~securing and~~ accounting for wasted ~~or discarded drugs~~ controlled substances. Waste documentation must include at least the following: ~~(3-21-12)~~( )

a. Date and time of transaction; (3-21-12)

b. Patient name and location; (3-21-12)

c. Drug and dose; (3-21-12)

~~**d.** Quantity of transaction; (3-21-12)~~

~~**e**~~**d.** Wasted amount; (3-21-12)

~~**f.** Beginning and ending count (for controlled substances only); (3-21-12)~~

~~**g**~~**e.** ~~Nurse~~ Authorized user identification; and ~~(3-21-12)~~( )

~~**h**~~**f.** Witness identification~~, if needed~~. ~~(3-21-12)~~( )

05. Supervising Pharmacy Identification. If used in a nursing home, the ADS system must be clearly marked with the name, address, and phone number of the supervising pharmacy and pharmacist-in-charge. (3-21-12)

293. VENDING MACHINES.
Only non-prescription medical supplies and drugs that are unrestricted for over-the-counter sale may be stored and sold in vending machines *which* are subject to inspection by the Board upon

reasonable notice. *( )*

29~~2~~4. -- 299. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

632. INSTITUTIONAL FACILITY: EMERGENCY DRUG SUPPLY PREPARATION AND MONITORING.
The director or PIC and the appropriate institutional facility personnel must jointly approve and develop a listing of drugs, by identity and quantity, for inclusion in an emergency cabinet, emergency kit, crash cart, or other similar resource that is specifically approved for use by that type of institutional facility and for delivery to patients receiving emergency treatment. In addition to other applicable provisions of these rules, approved drugs are subject to the following limitations, restrictions, and requirements: (3-21-12)

01. Prepackaged Amounts. The drugs must be prepackaged in amounts sufficient to satisfy immediate therapeutic requirements only, except when delivered in a hospital emergency room consistent with these rules; *~~(3-21-12)~~( )*

02. Content Labeling. The drugs must be labeled as required by these rules for prepackaged products and with any additional information as may be required to prevent misunderstanding or risk of harm to patients; (3-21-12)

03. Access Documentation. Access to the emergency drugs must be documented by drug orders and, if applicable, proofs of use; (3-21-12)

04. Drug Expiration Monitoring. Drug expiration dates must be monitored and the drugs replaced as needed to ensure the emergency drug supply contains no outdated products; and (3-21-12)

05. Regular Inventory and Inspection. Emergency drug supplies must be regularly inventoried and inspected to ensure that they are properly stored and secured against pilferage or tampering. (3-21-12)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1204

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2013 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 3, 2012 Idaho Administrative Bulletin, **Vol. 12-10, pages 660 through 664**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Johnston, Executive Director, at (208) 334-2356 or at **mark.johnston@bop.idaho.gov**.

DATED this 30th day of November, 2012.

Mark Johnston, R.Ph.
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Telephone: (208) 334-2356
FAX: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to 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 October 17, 2012.

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

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

To clarify the practice limitations of pharmacists and the members of a committee. To clarify that a pharmacist may order lab tests and substitute drug product in certain circumstances, but may not conduct physical examinations or engage in the practice of medicine; and to require that a pharmacist serve on a skilled nursing facility's quality assurance and assessment committee.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012 Idaho Administrative Bulletin, **Vol. 12-5, Page 82**, and in the August 1, 2012 Idaho Administrative Bulletin, **Vol. 12-8, page 73**, Docket No. 27-0101-1201.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mark Johnston, R.Ph., Executive Director, at (208) 334-2356.

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 October 24,

2012.

DATED this 6th day of September, 2012.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1204

011. DEFINITIONS AND ABBREVIATIONS (J -- R).

01. LTCF -- Long-Term Care Facility. An institutional facility that provides extended health care to resident patients. (3-21-12)

02. MPJE. Multistate Pharmacy Jurisprudence Exam. (3-21-12)

03. MTM -- Medication Therapy Management. A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision or administration of a drug or a device and encompass a broad range of activities and responsibilities. The MTM service model in pharmacy practice includes the following five core elements: (3-21-12)

a. Medication therapy review; (3-21-12)

b. Personal medication record; (3-21-12)

c. Medication-related action plan; (3-21-12)

d. Intervention or referral, or both; (3-21-12)

e. Documentation and follow-up. (3-21-12)

04. NABP. National Association of Boards of Pharmacy. (3-21-12)

05. NAPLEX. North American Pharmacists Licensure Examination. (3-21-12)

06. NDC. National Drug Code. (3-21-12)

07. Non-Institutional Pharmacy. A pharmacy located in a drug outlet that is not an institutional facility. (3-21-12)

08. Parenteral Admixture. The preparation and labeling of sterile products intended for administration by injection. (3-21-12)

09. Pharmaceutical Care Services. A broad range of pharmacist-provided cognitive services, activities and responsibilities intended to optimize drug-related therapeutic outcomes for

patients. Pharmaceutical care services may be performed independent of, or concurrently with, the dispensing or administration of a drug or device and encompasses services provided by way of DTM under a collaborative practice agreement, pharmacotherapy, clinical pharmacy practice, pharmacist independent practice, and MTM. Except as permitted pursuant to a collaborative practice agreement, ~~N~~nothing in these rules allows a pharmacist, beyond what is statutorily allowed ~~*or allowed by a collaborative practice agreement*~~, to engage in the unlicensed practice of medicine or to diagnose, prescribe, ~~*order lab tests,*~~ or conduct ~~*complete*~~ physical examinations. Pharmaceutical care services are not limited to, but may include one (1) or more of the following, according to the individual needs of the patient: ~~*(3-21-12)*~~( )

a. Performing or obtaining necessary assessments of the patient's health status, including the performance of health screening activities that may include, but are not limited to, obtaining finger-stick blood samples; (3-21-12)

b. Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; (3-21-12)

c. Monitoring and evaluating the patient's response to drug therapy, including safety and effectiveness; (3-21-12)

d. Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; (3-21-12)

e. Documenting the care delivered; (3-21-12)

f. Communicating essential information or referring the patient when necessary or appropriate; (3-21-12)

g. Providing counseling education, information, support services, and resources applicable to a drug, disease state, or a related condition or designed to enhance patient compliance with therapeutic regimens; (3-21-12)

h. Conducting a drug therapy review consultation with the patient or caregiver; (3-21-12)

i. Preparing or providing information as part of a personal health record; (3-21-12)

j. Identifying processes to improve continuity of care and patient outcomes; (3-21-12)

k. Providing consultative drug-related intervention and referral services; (3-21-12)

l. Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; and (3-21-12)

m. Other services as allowed by law. (3-21-12)

10. Pharmacist Extern. A person enrolled in an accredited school or college of

pharmacy who is pursuing a professional degree in pharmacy and is obtaining practical experience under the supervision of a pharmacist. (3-21-12)

11. Pharmacist Intern. A person who has successfully completed a course of study at an accredited school or college of pharmacy, has received a professional degree in pharmacy, and is obtaining practical experience under the supervision of a pharmacist. (3-21-12)

12. Pharmacy Operations. Activities related to and including the preparation, compounding, distributing, or dispensing of drugs or devices from a pharmacy. (3-21-12)

13. PHI -- Protected Health Information. Individually identifiable health information that is: (3-21-12)

a. Transmitted by electronic media (as defined by the HIPAA Privacy Rule at 45 CFR 160.103); (3-21-12)

b. Maintained in electronic media; and (3-21-12)

c. Transmitted or maintained in any other form or medium. (3-21-12)

d. PHI excludes individually identifiable health information in: (3-21-12)

i. Education records covered by the Family Education Right and Privacy Act, as amended (20 U.S.C. Section 1232g); (3-21-12)

ii. Records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv); and (3-21-12)

iii. Employment records held by a covered entity (as defined by the HIPAA Privacy Rule at 45 CFR 160.103) in its role as an employer. (3-21-12)

14. PIC. Pharmacist-in-charge. (3-21-12)

15. PMP. Prescription Monitoring Program. (3-21-12)

16. Prepackaging. The act of transferring a drug, manually or using an automated system, from a manufacturer's original container to another container prior to receiving a prescription drug order. (3-21-12)

17. Prescriber. An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. (3-21-12)

18. Prescriber Drug Outlet. A drug outlet in which prescription drugs or devices are dispensed directly to patients under the supervision of a prescriber, except where delivery is accomplished only through on-site administration or the provision of drug samples. (3-21-12)

19. Readily Retrievable. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-21-12)

20. Relative Contraindication. A condition that renders a particular treatment or procedure inadvisable, but not prohibitive. (3-21-12)

21. Remote Dispensing Site. A licensed pharmacy staffed by one or more certified technicians at which telepharmacy services are provided through a supervising pharmacy. (3-21-12)

22. Retail Non-Pharmacy Drug Outlet. A retail outlet that sells non-prescription drugs or devices that is not a pharmacy. (3-21-12)

23. Retail Pharmacy. A community or other pharmacy that sells prescription drugs at retail and is open to the public for business. (3-21-12)

24. R.N. Registered nurse. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

130. DRUG PRODUCT: SUBSTITUTION.
Drug product substitutions are allowed only ~~*in situations requiring compliance with*~~ as follows: ( )

01. Hospital. Pursuant to a formulary or drug list prepared by the pharmacy and therapeutics committee of a hospital; ~~*or*~~ ( )

02. Skilled Nursing Facility. At the direction of the quality assessment and assurance committee of a skilled nursing facility consisting of the director of nursing services, a physician designated by the facility, a consultant pharmacist, and at least ~~*three*~~ two (~~3~~2) other members of the facility's staff~~.~~; or ~~*(3-21-12)*~~( )

03. Drug Shortage. Upon a drug shortage, a pharmacist, using his best professional judgment, without contacting the prescriber, may substitute an alternative dose of a prescribed drug, so long as the prescriber's directions are also modified, to equate to an equivalent amount of drug dispensed as is prescribed. ( )

(BREAK IN CONTINUITY OF SECTIONS)

500. UNPROFESSIONAL CONDUCT.
The following acts or practices by a pharmacist, student pharmacist, or technician are declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest. (3-21-12)

01. Unethical Conduct. Conduct in the practice of pharmacy or in the operation of a

pharmacy that may reduce the public confidence in the ability and integrity of the profession of pharmacy or endangers the public health, safety, and welfare. A violation of this section includes committing fraud, misrepresentation, negligence, concealment, or being involved in dishonest dealings, price fixing, or breaching the public trust with respect to the practice of pharmacy. (3-21-12)

02. Lack of Fitness. A lack of fitness for professional practice due to incompetency, personal habits, drug or alcohol dependence, physical or mental illness, or for any other cause that endangers public health, safety, or welfare. (3-21-12)

03. On-Duty Intoxication or Impairment. Intoxication, impairment, or consumption of alcohol or drugs while on duty, including break periods after which the individual is expected to return to work, or prior to reporting to work. (3-21-12)

04. Diversion of Drug Products and Devices. Supplying or diverting drugs, biologicals, and other medicines, substances, or devices legally sold in pharmacies that allows the circumvention of laws pertaining to the legal sale of these articles. (3-21-12)

05. Unlawful Possession or Use of Drugs. Possessing or using a controlled substance without a lawful prescription drug order. A failed drug test creates a rebuttable presumption of a violation of this rule. (3-21-12)

06. Prescription Drug Order Noncompliance. Failing to follow the instructions of the person writing, making, or ordering a prescription as to its refills, contents, or labeling except as provided in these rules. ~~(3-21-12)~~( )

07. Failure to Confer. Failure to confer with the prescriber when necessary or appropriate or filling a prescription if necessary components of the prescription drug order are missing or questionable. (3-21-12)

08. Excessive Provision of Controlled Substances. Providing a clearly excessive amount of controlled substances. Evidentiary factors of a clearly excessive amount include, but are not limited to, the amount of controlled substances furnished and previous ordering patterns (including size and frequency of orders). (3-21-12)

09. Failure to Counsel or Offer Counseling. Failing to counsel or offer counseling, unless specifically exempted or refused. The failure to retain appropriate documentation evidencing compliance with patient counseling requirements creates a rebuttable presumption of a violation of this rule. (3-21-12)

10. Substandard, Misbranded, or Adulterated Products. Manufacturing, compounding, delivering, dispensing, or permitting to be manufactured, compounded, delivered, or dispensed substandard, misbranded, or adulterated drugs or preparations or those made using secret formulas. (3-21-12)

11. Prescriber Incentives. Allowing a commission or rebate to be paid, or personally paying a commission or rebate, to a person writing, making, or otherwise ordering a prescription. (3-21-12)

12. Exclusive Arrangements. Participation in a plan or agreement that compromises the quality or extent of professional services or limits access to provider facilities at the expense of public health or welfare. (3-21-12)

13. Failure to Report. Failing to report to the Board any violation of statutes or rules pertaining to the practice of pharmacy or any act that endangers the health, safety, or welfare of patients or the public. (3-21-12)

14. Failure to Follow Board Order. Failure to follow an order of the Board. (3-21-12)