# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 - MEDICAID BASIC PLAN BENEFITS

## DOCKET NO. 16-0309-1301

## NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 28, 2013.

DATED this 9th day of July, 2013.

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**THE FOLLOWING IS THE TEMPORARY RULE AND THE TEXT OF THE PROPOSED RULE FOR DOCKET NO. 16-0309-1301**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***(BREAK IN CONTINUITY OF SECTIONS)***

## 009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

***(BREAK IN CONTINUITY OF SECTIONS)***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**03. Physician**. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a State or United States territory. (3-30-07)

**04. Physician Assistant (PA)**. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-30-07)

**05. Plan of Care**. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-30-07)

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

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

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

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

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

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

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

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

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

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

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

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

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

**14~~5~~. Psychologist, Licensed**. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-30-07)

**15~~6~~. Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-30-07)

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

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

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

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

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

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

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

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

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

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

**2~~6~~7.** **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-30-07)

**2~~7~~8.** **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-30-07)

**2~~8~~9.** **Third Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. (3-30-07)

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

*(BREAK IN CONTINUITY OF SECTIONS)*

**150. CHOICE OF PROVIDERS.**

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

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

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

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

*(BREAK IN CONTINUITY OF SECTIONS)*

**230. GENERAL PAYMENT PROCEDURES.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***(BREAK IN CONTINUITY OF SECTIONS)***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**c.** Podiatrist services are described in Sections 540 through 545. (3-29-12)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**10.** ~~***Substance Abuse Treatment Services**. Services for substance abuse treatment are described in Sections 690 through 699 of these rules.*~~ **Outpatient Behavioral Health Services**. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. ~~*(5-8-09)*~~(9-1-13)T

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

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

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

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

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

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

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

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

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

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

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

**17.** **Dental Services**. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)

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

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

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

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

**d.** School-Based services are described in Sections 850 through 85~~6~~7. ~~*(3-30-07)*~~(9-1-13)T

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

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

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

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

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

*(BREAK IN CONTINUITY OF SECTIONS)*

**500. PHYSICIAN SERVICES: DEFINITIONS.**

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

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

**501. (RESERVED)**

**502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.**

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

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

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

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

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

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

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

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

*(BREAK IN CONTINUITY OF SECTIONS)*

**611. -- 614. (RESERVED)**

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

~~***01. Enhanced Mental Health Services**. Enhanced mental health services are not covered under the Basic Plan with the exception of assessment services. The assessment for determination of need for enhanced mental health services is subject to the requirements for comprehensive assessments at IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 114, and provider qualifications under Section 715 of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131.* (3-29-12)~~

~~***02. Service Coordination Services**. Service coordination services are not covered under the Basic Plan, with the exception of assessment services. The assessment for the need for service coordination services is subject to the requirements for service coordination under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 727.03, as applicable to the service being requested, and provider qualifications under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 729.* (3-30-07)~~

*(BREAK IN CONTINUITY OF SECTIONS)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

693. SUBSTANCE ABUSE TREATMENT SERVICES: PROCEDURAL REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***(BREAK IN CONTINUITY OF SECTIONS)***

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

~~***01. Adult.*** *An adult is an individual who is eighteen (18) years of age or older for the purposes of Mental Health Clinic and other outpatient mental health services.* (3-30-07)~~

~~***02. Comprehensive Diagnostic Assessment.*** *A thorough assessment of the participant's current condition and complete medical and psychiatric history.* (5-8-09)~~

~~03. Comprehensive Diagnostic Assessment Addendum. A supplement to the comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (3-29-12)~~

~~04. Interdisciplinary Team. Group that consists of two (2) or more individuals in addition to the participant, the participant's parent or legal guardian, and the participant's natural supports. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)~~

~~05. Level of Care. Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)~~

~~06. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders. (5-8-09)~~

~~07. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. (3-30-07)~~

~~08. Neuropsychological Testing. Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system; the data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)~~

~~09. New Participant. A participant is considered "new" if he has not received Medicaid reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (3-29-12)~~

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

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

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

~~13. Psychiatric Nurse, Licensed Master's Level. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (3-30-07)~~

~~14. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or~~

~~functional impairments.~~ ~~(3-30-07)~~

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

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

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

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

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

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

~~**17. Seclusion**. Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is prevented from leaving.~~ ~~(5-8-09)~~

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

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

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

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

~~**d.** A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance.~~ ~~(5-8-09)~~

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

~~**a.** Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and~~ ~~(5-8-09)~~

~~**b.** Must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.~~ ~~(5-8-09)~~

~~**20. Serious and Persistent Mental Illness (SPMI)**. Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive~~

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

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

**708. ~~*MENTAL*~~ OUTPATIENT BEHAVIORAL HEALTH ~~*CLINIC*~~ SERVICES: PARTICIPANT ELIGIBILITY.**

~~*Eligibility must be established through the assessment services described under Subsections 709.03.a. and 709.03.b. of these rules. The following are requirements for establishing eligibility for mental health clinic services.~~ All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare-Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary.
~~(5-8-09)~~(9-1-13)T

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

~~***02. Healthy Connections Referral**. A participant who belongs to the Healthy Connections program must be referred to the mental health clinic by his Healthy Connections physician.* (5-8-09)~~

~~***03. Establishment of Service Needs**. The initial assessment of the participant must establish that the services requested by the participant or his legal guardian are therapeutically appropriate and can be provided by the clinic.* (5-8-09)~~

~~***04. Conditions That Require New Assessment and Individualized Treatment Plan**. If an individual who is not eligible for Medicaid receives assessment services from any staff who does not have the qualifications required under Subsection 715.03 of these rules, and later becomes eligible for Medicaid, a new comprehensive diagnostic assessment and individualized treatment plan are required, which must be developed by a professional listed under Subsection 715.03 of these rules.* (3-29-12)~~

**709. ~~*MENTAL*~~ OUTPATIENT BEHAVIORAL HEALTH ~~*CLINIC*~~ SERVICES: COVERAGE AND LIMITATIONS.**

~~*All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual.* (3-30-07)~~

~~***01. Clinic Services -- Mental Health Clinics (MHC)**. Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 229.* (3-30-07)~~

~~***02. Services or Supplies in Mental Health Clinics That Are Not Reimbursed**. Any service or supplies not included as part of the allowable scope of Medicaid.* (5-8-09)~~

~~***03. Evaluation and Diagnostic Services in Mental Health Clinics**. Participants must obtain a comprehensive diagnostic assessment as the initial evaluation in mental health clinics.* (3-29-12)~~

~~***a.** The comprehensive diagnostic assessment must include a current mental status examination, a description of the participant's readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan. The assessment must include the five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. A*~~

~~comprehensive diagnostic assessment is a reimbursable service when:~~ ~~(3-29-12)~~

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

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

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

~~**b.** Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. The psychological report must contain the reason for the performance of this service. Agency staff may deliver this service if they meet one (1) of the following qualifications:~~ ~~(5-8-09)~~

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

~~ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or~~ ~~(3-30-07)~~

~~iii. A qualified therapist listed in Subsection 715.03 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing.~~ ~~(3-30-07)~~

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

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

~~**04. Psychotherapy Treatment Services in Mental Health Clinics**. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan as described in Section 710 of these rules.~~ ~~(5-8-09)~~

~~**05. Family Psychotherapy**. Family psychotherapy services must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. The focus of family psychotherapy is on the dynamics within the family structure as it relates to the participant.~~ ~~(5-8-09)~~

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

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

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

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

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

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

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

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

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

*a. Emergency services provided to an eligible participant prior to the completion of a comprehensive diagnostic assessment must be fully documented in the participant's medical record; and (3-29-12)*

*b. Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations even when contact does not result in the hospitalization of the participant. (3-30-07)*

***07. Pharmacological Management**. Pharmacological management is a reimbursable service when consultations are provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (5-8-09)*

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

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

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

*a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nursing Practice Act, Section 54-1402, Idaho Code; and (3-30-07)*

*b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (3-30-07)*

***09. Limits on Mental Health Clinic Services**. Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of evaluation, diagnosis and treatment services. A total of four (4) hours per year is the maximum time allowed for diagnostic assessment services. Psychological and neuropsychological testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (3-29-12)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~*A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules.*~~ The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department. ~~*(3-29-12)*~~(9-1-13)T

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

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

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

~~***02. Individualized Treatment Plan Requirements.*** *An individualized treatment plan must include, at a minimum, the following:* (3-30-07)~~

~~***a.*** *Statement of the overall goals as identified by the participant or his parent or legal guardian and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized, and must reflect the choices of the participant or his parent or legal guardian. The goals and objectives must address the emotional, behavioral, and skill training needs identified by the*~~

~~participant or his parent or legal guardian through the intake and assessment process. The tasks must be specific to the type of modality used and must specify the frequency and anticipated duration of therapeutic services.~~ ~~(5-8-09)~~

~~**b.** Documentation of who participated in the development of the individualized treatment plan.~~ ~~(3-30-07)~~

~~i. The authorizing physician must sign and date the plan within thirty (30) calendar days of the initiation of treatment.~~ ~~(3-30-07)~~

~~ii. The participant, when able, and his parent or legal guardian must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the participant and his parent or legal guardian.~~ ~~(5-8-09)~~

~~iii. Other individuals who participated in the development of the treatment plan must sign the plan.~~ ~~(3-30-07)~~

~~iv. The author of the treatment plan must sign and date the plan and include his title and credentials.~~ ~~(5-8-09)~~

~~**c.** The treatment plan must be created in direct response to the findings of the assessment process.~~ ~~(3-29-12)~~

~~**d.** The treatment plan must include a prioritized list of issues for which treatment is being sought, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services.~~ ~~(5-8-09)~~

~~**e.** Tasks that are specific, time limited activities and interventions designed to accomplish the objectives in the individualized treatment plan that are recommended by the participant's interdisciplinary team and agreed to by the participant or his parent or legal guardian. Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to provide the service.~~ ~~(5-8-09)~~

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

~~**03. Treatment Plan Reviews**. The agency staff must conduct intermittent treatment plan reviews when medically necessary. The intermittent treatment plan reviews must be conducted with the participant or his legal guardian at least every one hundred twenty (120) days. During the reviews, the agency staff providing the services, the participant, and any other members of the participant's interdisciplinary team as identified by the participant or his legal guardian must review the progress the participant has made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the participant or his legal guardian and agency staff providing the services.~~ ~~(5-8-09)~~

~~**04. Physician Review of Treatment Plan**. Each individualized treatment plan must be reviewed, updated, and signed by a physician at least annually. Changes in the types, duration, or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the revision of the individualized treatment plan must be recorded on the treatment plan.~~ ~~(3-29-12)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**713. MENTAL HEALTH CLINIC SERVICES: RESPONSIBILITIES OF THE DEPARTMENT.** The Department will administer the provider agreement for the provision of mental health clinic services and is responsible for the following tasks: (3-29-12)

**01. Prior Authorization Process**. Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services. (3-29-12)

**02. Notice of Decision**. At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (3-29-12)

**03. Responding to Requests for Services**. When the Department receives from a provider a written request for services that must be prior authorized, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (3-29-12)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~h. Licensed Professional Counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (5-8-09)~~

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

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

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

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

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

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

~~02. Informed Consent. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For a minor child, informed consent must be obtained from the minor's parent or legal guardian. (5-8-09)~~

~~03. Documentation. All assessments and testing evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (3-29-12)~~

~~04. Data. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (3-30-07)~~

~~05. Mental Health Clinic Record Keeping Requirements. (3-30-07)~~

~~a. Maintenance. Each mental health clinic will be required to maintain records on all services provided to Medicaid participants. (5-8-09)~~

~~b. Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 710 of this rule. (5-8-09)~~

~~c. Requirements. The records must: (3-30-07)~~

~~i. Specify the exact type of treatment provided; and (3-30-07)~~

~~ii. Who the treatment was provided by; and (3-30-07)~~

~~iii. Specify the duration of the treatment and the time of day delivered; and (3-30-07)~~

~~*iv. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and* (3-30-07)~~

~~*v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service.* (3-30-07)~~

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

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

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

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

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

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

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

***(BREAK IN CONTINUITY OF SECTIONS)***

**850. SCHOOL-BASED SERVICE: DEFINITIONS.**

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

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

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

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

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

services. (7-1-13)

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

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

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

**07.** **Serious and Persistent Mental Illness (SPMI)**. A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (9-1-13)T

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**a.** A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, and have documented evidence of a history and physical examination that has been completed within the last twelve (12) months prior to the initiation of mental health services. A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the medical record. The Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following: Self-harmful Behavior, Moods/Emotions, or Thinking. In addition, the child must have obtained a comprehensive diagnostic assessment that indicates: (9-1-13)T

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

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

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

**b.** A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training

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

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

ii Financial; (9-1-13)T

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**c.** Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school by the student. (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

~~*(3-29-10)*~~(9-1-13)T

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

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

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

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

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

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)

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

v. The mileage, as well as the services performed by the attendant, are documented. See Section 85~~4~~5 of these rules for documentation requirements. ~~(3-30-07)~~(9-1-13)T

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**04. One Hundred Twenty Day Review**. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (7-1-13)

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

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

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

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

**07. Parental Notification**. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 8534.08 of this rule. ~~(7-1-13)~~(9-1-13)T

**08. Requirements for Cooperation with and Notification of Parents and Agencies**. Each school district or charter school billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (7-1-13)

**a.** Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (7-1-13)

**b.** Notification to Primary Care Physician. School districts and charter schools must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (7-1-13)

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

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

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

(7-1-13)

**c.** Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**h.** Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (7-1-13)

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

**j.** Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (7-1-13)

**k.** Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**11. Speech/Audiological Therapy and Evaluation**. Speech/audiological therapy and evaluation must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. (7-1-13)

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

**13. Transportation**. Transportation must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-13)

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

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

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

**c.** Speech-Language Pathology. Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. (7-1-13)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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