IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DATED this 9th day of July, 2013.

Tamara Prisock
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THE FOLLOWING IS THE TEMPORARY RULE AND THE TEXT OF THE PROPOSED RULE FOR DOCKET NO. 16-0310-1301

001. TITLE AND SCOPE.

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (5-8-09)

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

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

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

07. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

08. Developmental Disabilities Services. (3-19-07)

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)

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

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

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

e. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)

09. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

10. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

~~111. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DEFINITIONS.~~
~~These definitions apply to Sections 100 through 146 of these rules. (3-19-07)~~

~~**01. Agency**. A Medicaid provider who delivers either mental health clinic services or psychosocial rehabilitative services, or both. (5-8-09)~~

~~**02. Community Reintegration**. A psychosocial rehabilitation (PSR) service that provides practical information and direct support to help the participant maintain his current skills, prevent regression, or practice newly-acquired life skills. The intention of this service is to provide the information and support needed by a participant to achieve the highest level of stability and independence that meets his ongoing recovery needs. (5-8-09)~~

~~**03. Comprehensive Diagnostic Assessment**. A thorough assessment of the participant's current condition and complete medical and psychiatric history. (5-8-09)~~

~~**04. Comprehensive Diagnostic Assessment Addendum**. A supplement to the comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (3-29-12)~~

~~**05. Demographic Information**. Information that identifies participants and is entered into the Department's database collection system. (3-19-07)~~

~~**06. Duration of Services**. Refers to length of time for a specific service to occur in a single encounter. (5-8-09)~~

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

~~**08. Initial Contact**. The date a participant, or participant's parent or legal guardian comes in to an agency and requests Enhanced Plan services. (5-8-09)~~

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

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

~~11. **Level of Care**. Clinical treatment decisions that determine service site, modality, urgency, and specific interventions needed to address the key presenting signs, symptoms, and environmental factors that indicate the severity of illness and the intensity of service needed by the participant. It also takes into account relevant external factors affecting clinical treatment decisions. (5-8-09)~~

~~12. **Licensed Practitioner of the Healing Arts**. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing medications for psychiatric disorders. (5-8-09)~~

~~13. **Neuropsychological Testing**. Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system. The data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)~~

~~14. **New Participant**. A participant is considered "new" if he has not received Medicaid reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (3-29-12)~~

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

~~16. **Occupational Therapy**. For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. (5-8-09)~~

~~17. **Partial Care**. Partial care is treatment for participants with serious and persistent mental illness (SPMI) whose functioning is sufficiently disrupted to the extent that it interferes with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. (3-29-12)~~

~~18. **Pharmacological Management**. The in-depth management of medications for psychiatric disorders for relief of a participant's signs and symptoms of mental illness, provided by a licensed practitioner of the healing arts. (5-8-09)~~

~~19. **Psychiatric Nurse, Licensed Master's Level**. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (5-8-09)~~

~~20. **Psychosocial Rehabilitative Services (PSR)**. An array of rehabilitative services that emphasize resiliency for children with serious emotional disturbance (SED) and recovery for adults with serious and persistent mental illness (SPMI). Services target skills for children that they would have appropriately developed for their developmental stage had they not developed symptoms of SED. Services target skills for adults that have been lost~~

~~due to the symptoms of their mental illness.~~ ~~(5-8-09)~~

~~**21. Psychotherapy**. A method of treating and managing psychiatric disorders through the use of evidenced-based psychological treatment modalities that match the participant's ability to benefit from the service. The focus of the service is on behavioral, emotional, and cognitive aspects of a participant's functioning.~~ ~~(5-8-09)~~

~~**22. Psychological Testing**. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments.~~ ~~(5-8-09)~~

~~**23. Restraints**. Restraints include the use of physical, mechanical, or chemical interventions, or other means to temporarily subdue or modify participant behavior.~~ ~~(5-8-09)~~

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

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

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

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

~~**24. Seclusion**. Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is prevented from leaving.~~ ~~(5-8-09)~~

~~**25. Serious Emotional Disturbance (SED)**. In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is:~~ ~~(5-8-09)~~

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

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

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

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

~~**26. Serious Mental Illness (SMI)**. In accordance with 42 CFR 483.102(b)(1), a person with SMI:~~ ~~(5-8-09)~~

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

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

~~**27. Serious and Persistent Mental Illness (SPMI).** Participants must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-IV-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (5-8-09)~~

~~**28. Skill Training**. The service of providing a curriculum-based method of skill building in a custom-tailored approach that meets the needs identified on the person's assessment, focuses on interventions that are necessary to maintain functioning, prevent regression, or achieve a rehabilitation goal, and promotes increased independence in thinking and behavior. Skill training may be delivered individually or in groups. (5-8-09)~~

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

~~**30. Treatment Plan Review**. The practice of obtaining input from members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant. This review should provide feedback and suggestions intended to help team members and the participant to accomplish the participant's goals identified on the participant's individualized treatment plan. (5-8-09)~~

~~**31. USPRA**. The United States Psychiatric Rehabilitation Association is an association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. USPRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. http://www.uspra.org (5-8-09)~~

~~**112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.**~~
~~To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 114 of these rules. The comprehensive diagnostic assessment for enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out of home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. (4-4-13)~~

~~**01. General Participant Eligibility Criteria**. The medical record must have documented evidence of a history and physical examination that has been completed by a participant's primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service. Participants who are in crisis as described at Subsection 123.04 of this rule may receive mental health services prior to obtaining a history and physical examination. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and documented in the comprehensive diagnostic assessment: (5-8-09)~~

~~**a.** The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant. (5-8-09)~~

~~**b.** The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-2-08)~~

~~**c.** Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services: (4-2-08)~~

~~i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (4-2-08)~~

~~ii. Participants needing more restrictive care or inpatient care; and (4-2-08)~~

~~iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (4-2-08)~~

~~02. Eligibility Criteria for Children. To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED). (5-8-09)~~

~~03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI). (5-8-09)~~

~~04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (4-2-08)~~

~~a. Children must meet Subsections 112.01 and 112.02 of this rule. (4-2-08)~~

~~b. Adults must meet Subsections 112.01 and 112.03 of this rule. (4-2-08)~~

~~05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services for Children. (4-4-13)~~

~~a. To be eligible for the PSR services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.01 and 112.02 of this rule and must experience a substantial impairment in functioning. (4-4-13)~~

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

~~c. A child's level and type of functional impairment must be documented in the medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. (4-4-13)~~

~~d. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: self harmful behavior, moods/emotions, or thinking. (4-4-13)~~

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

~~a. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.c.i. through 112.06.c.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. (4-4-13)~~

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

~~c. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the adult's level and type of functional impairment must be documented in the medical record in the following areas: (4-4-13)~~

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

ii. Financial; (4-2-08)

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

iv. Family; (4-2-08)

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

vi. Housing; (4-2-08)

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

viii. Health/medical. (4-2-08)

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and documented in the medical record within ten (10) days of discharge. (5-8-09)

i. Up to two (2) hours of plan development hours may be used for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Section 114 of these rules. (5-8-09)

ii. Upon initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. A comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. (3-29-12)

b. In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the plan must be updated and the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. (3-29-12)

113. (RESERVED)

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

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

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

115. (RESERVED)

116. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES -- WRITTEN INDIVIDUALIZED TREATMENT PLAN.
A written individualized treatment plan must be developed and implemented for each participant of enhanced outpatient mental health services as a means to address the enhanced service needs of the participant. Each individualized treatment plan must specify the individual staff person responsible for providing each service, and the amount, frequency and expected duration of treatment. The development of the initial treatment plan is reimbursable if conducted by a professional identified in Subsections 131.01 through 131.03 of these rules. When the assessment indicates that the participant would benefit from psychotherapy or additional diagnostic services, the treatment plan must be completed by a qualified professional listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. (3-29-12)

01. Goals. Services identified on the treatment plan must support the goals that are applicable to the participant's identified needs. For adults, their treatment plan must incorporate the need for psychiatric services identified by the comprehensive diagnostic assessment. For children, their treatment plan must incorporate the substantial impairment areas identified by the CAFAS. Participant's goals may include any of the following: (3-29-12)

a. Skill Training. The goal is to assist the participant in regaining skills that have been lost due to the symptoms of his mental illness or that would have been otherwise developed except for the interference of his mental health condition. Through skill training, the participant should achieve maximum reduction of symptoms of mental illness or serious emotional disturbance that will allow for the greatest adjustment to living in the community. (5-8-09)

b. Community Reintegration. The goal is to provide practical information and support for the participant to be able to be effectively involved in the rehabilitation process. (5-8-09)

c. Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (3-19-07)

d. Psychotherapy. The goal is to engage in active treatment that involves psychological strategies for problem resolution to promote optimal functioning and a condition of improved mental health. (5-8-09)

e. Pharmacological Management. The goal is to obtain a decrease or remission of symptoms of psychiatric illness and improve quality of life through the use of pharmacological agents without causing adverse effects. (5-8-09)

02. Plan Content. An individualized treatment plan must meet the requirements listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 710. Additionally, at least one (1) objective is required in the areas that are most likely to lead to the greatest level of stabilization. (5-8-09)

03. Plan Timeframes. An individualized treatment plan must be developed and signed by a licensed physician or other licensed practitioner of the healing arts within thirty (30) calendar days from initial contact. Intermittent treatment plan reviews must occur as needed to incorporate progress, different goals, or change in treatment focus, but must not exceed one hundred twenty (120) days between reviews. An updated treatment plan must be developed for participants who will continue in treatment beyond twelve (12) months. (3-29-12)

04. Choice of Providers. The participant or his parent or legal guardian must be allowed to choose whether or not he desires to receive enhanced outpatient mental health services and which provider agency or agencies he would like to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's medical record showing that the participant or his parent or legal guardian has been informed of his rights to refuse services and choose provider agencies. (5-8-09)

05. No Duplication of Services. The provider agency or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to enhanced outpatient mental health services participants through other Medicaid reimbursable and non-Medicaid programs. (3-19-07)

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

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DESCRIPTIONS.

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to twelve (12) hours per week per eligible participant. (5-8-09)

a. In order to be considered a partial care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and outcomes; and (3-29-12)

iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (5-8-09)

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation, or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. Participants who receive skill training in Partial Care cannot receive skill training in psychosocial rehabilitation services. (4-4-13)

119. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Medical Assistance Upper Limit. The Department's medical assistance upper limit for reimbursement is the lower of: (3-21-12)

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

b. The allowable charge as established by the Department's medical assistance fee schedule. Mental health clinic reimbursement is subject to the provisions of 42 CFR 447.321. (3-21-12)

02. Reimbursement. For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (3-21-12)

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

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

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

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

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

~~b. Assistance in gaining and utilizing skills necessary for managing personal finances, living arrangements, and daily home care duties.~~ ~~(5-8-09)~~

~~c. Individual interventions in social skill training directly related to the participant's mental illness to improve community functioning and to facilitate appropriate interpersonal behavior.~~ ~~(5-8-09)~~

~~d. Assistance in gaining and utilizing cognitive skills for problem solving everyday dilemmas, listening, symptom management, and self-regulation.~~ ~~(5-8-09)~~

~~e. Assistance for gaining and utilizing communications skills for the participant to be able to express himself coherently to others including other service providers.~~ ~~(5-8-09)~~

~~i. For participants receiving skill training for communication issues who cannot express necessary information to his healthcare providers or understand instructions given to him by healthcare providers, the PSR agency staff person may accompany the participant to medical appointments as a part of the communication skill training service.~~ ~~(5-8-09)~~

~~ii. For reimbursement purposes, the PSR agency staff person must deliver a skill training service that is identified on the treatment plan during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable.~~ ~~(5-8-09)~~

~~iii. The individualized treatment plan must identify how the issue is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child.~~ ~~(5-8-09)~~

~~f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness, symptom management, and adherence to the treatment regimen.~~ ~~(5-8-09)~~

~~g. Assistance for gaining and utilizing skills needed by the participant to arrange for his transportation, or to access and utilize the public transportation system.~~ ~~(5-8-09)~~

~~02. Community Reintegration. The service of community reintegration must be provided in accordance with the objectives specified in the individualized treatment plan. The service may include: (5-8-09)~~

~~a. Assisting the participant with self administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. (5-8-09)~~

~~b. Assisting the participant with maintaining or obtaining services that the participant usually takes care of for himself but is temporarily unable to do so because of an exacerbation of his symptoms. The targeted skills must be necessary to maintain his status in the home or community. (5-8-09)~~

~~c. Working with the participant's legal guardian immediately following the delivery of a mental health service in order to provide follow-up and support actions that facilitate the participant's positive response to the services. (5-8-09)~~

~~03. Group Skill Training. Group skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Group skill training is a service provided to two (2) or more individuals concurrently. Group skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following: (5-8-09)~~

~~a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness, symptom management, and skills for adhering to their medical regimen. These groups must not be used solely for the purpose of group prescription writing; (5-8-09)~~

~~b. Community Living skills groups that focus on occupation-related symptom management, symptom reduction, and skills related to appropriate job or school-related behaviors; (5-8-09)~~

~~c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-19-07)~~

~~d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and (3-19-07)~~

~~e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (3-19-07)~~

~~04. Crisis Intervention Service. Crisis support includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or refer the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. (5-8-09)~~

~~a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (3-19-07)~~

~~**b.** *Crisis Support in an Emergency Department.* (3-19-07)~~

~~i. *A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment.* (3-19-07)~~

~~ii. *The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant.* (3-19-07)~~

~~**c.** *Crisis Support Limitations. Crisis support services are available up to a total of ten (10) hours per week. This limitation is in addition to any other PSR service hours within that same time frame. Crisis support hours must be authorized by the Department.* (5-8-09)~~

~~**124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): COVERAGE AND LIMITATIONS.** *The following service limitations apply to PSR agency services, unless otherwise authorized by the Department.* (5-8-09)~~

~~**01. Assessment**. *Assessment services must not exceed four (4) hours per participant annually. The following assessments are included in this limitation:* (3-29-12)~~

~~**a.** *Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually;* (3-29-12)~~

~~**b.** *Occupational Therapy Assessment. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment.* (5-8-09)~~

~~**02. Psychological and Neuropsychological Testing**. *Testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment.* (3-29-12)~~

~~**03. Individualized Treatment Plan**. *Two (2) hours are available for the development of the participant's initial treatment plan. Following the development of the initial treatment plan, all subsequent treatment must be based on timely updates to the initial plan. Treatment plan updates are considered part of the content of care and should occur as an integral part of the participant's treatment experience.* (3-29-12)~~

~~**04. Psychotherapy**. *Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. Services beyond six (6) hours weekly must be prior-authorized.* (5-8-09)~~

~~**05. Crisis Intervention Service**. *A maximum of ten (10) hours of crisis support in a community may be authorized per crisis per seven (7) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. This limitation is in addition to any other PSR service hours within that same time frame.* (5-8-09)~~

~~**06. Skill Training and Community Reintegration**. *Services are limited to five (5) hours weekly in any combination of individual or group skill training and community reintegration for eligible participants up to twenty-one (21) years of age. For participants aged twenty-one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. Participants who receive skill training in psychosocial rehabilitation cannot receive skill training in partial care. Participants with both a developmental disability diagnosis and a qualifying mental health diagnosis, who want to receive skill training services from a PSR agency provider in addition to a developmental disability service provider, must obtain authorization from the Department prior to service implementation.* (4-4-13)~~

~~**07. Pharmacological Management**. *Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department.* (5-8-09)~~

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by an Occupational Therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)

09. Place of Service. PSR agency services are to be home and community-based. (5-8-09)

a. PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is necessary to maximize the impact of the service. (5-8-09)

b. PSR agency services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (5-8-09)

125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.
Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (3-19-07)

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.07 of these rules. (3-29-12)

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose. (3-19-07)

03. Employment. Job-specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (3-19-07)

04. Household Tasks. Staff performance of household tasks and chores. (3-19-07)

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant. (3-19-07)

06. Services Primarily Available Through Service Coordination Agencies. Any service that is typically addressed by Service Coordination as described in Section 727 of these rules, is not included in the program of psychosocial rehabilitation services. The PSR agency staff should refer participants to service coordination agencies for these services. (5-8-09)

07. Medication Drops. Delivery of medication only; (3-19-07)

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (3-19-07)

09. Transportation. The provision of transportation services and staff time to transport. (3-19-07)

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (3-19-07)

11. Services Not Listed. Any other services not listed in Section 123 of these rules. (3-19-07)

126. -- 127. (RESERVED)

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of PSR agency services and is responsible

~~for the following tasks:~~ ~~(5-8-09)~~

~~**01. Credentialing**. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712.~~ ~~(3-19-07)~~

~~**02. Prior Authorization Process**. Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services.~~ ~~(3-29-12)~~

~~**03. Notice of Decision**. At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian.~~ ~~(3-29-12)~~

~~**04. Responding to Requests for Services**. When the Department is notified, in writing, by the provider of services that require prior authorization, the Department must review the request and either approve or deny the request within ten (10) working days of receipt.~~ ~~(3-29-12)~~

~~**05. Service System**. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems.~~ ~~(3-19-07)~~

~~**129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER RESPONSIBILITIES.**~~

~~**01. Provider Agreement**. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR agency services and also is responsible for the following tasks:~~ ~~(5-8-09)~~

~~**02. Service Availability**. Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis.~~ ~~(5-8-09)~~

~~**03. Comprehensive Diagnostic Assessment and Individualized Treatment Plan Development**. The provider agency is responsible to conduct a comprehensive diagnostic assessment and develop an individualized treatment plan for each new participant with input from the interdisciplinary team if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs.~~ ~~(3-29-12)~~

~~**04. Individualized Treatment Plan**. The provider must develop an individualized treatment plan when one (1) has not already been developed in accordance with Section 116 of these rules. Providers must update the participant's treatment plan at least every one hundred twenty (120) days, or more frequently as necessary, until the participant is discharged from services. The signature of a licensed physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the services are medically necessary at least annually. The date of the initial plan is the date it is signed by the physician.~~ ~~(3-29-12)~~

~~**05. Changes to Individualized Treatment Plan Objectives**. When a provider believes that an individualized treatment plan needs to be revised, the provider should make those revisions in collaboration with the participant's interdisciplinary team and obtain required signatures. Amendments and modifications to the treatment plan objectives must be justified and documented in the medical record.~~ ~~(5-8-09)~~

~~**06. Effectiveness of Services**. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on~~

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

07. Healthy Connections Referral. *Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program.* *(3-19-07)*

130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER AGENCY REQUIREMENTS. *Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements:* *(3-19-07)*

01. Agency. *A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both direct and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll.* *(5-8-09)*

02. Criminal History Checks. *(3-19-07)*

a. *The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Criminal History and Background Checks."* *(3-19-07)*

b. *Once an employee, subcontractor, or agent of the agency has completed a self declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.* *(3-19-07)*

c. *Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction.* *(3-19-07)*

03. PSR Agency Staff Qualifications. *The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules and maintains ongoing compliance with the education requirements defined in Subsection 130.09 or Subsection 131.03.c.iii. of this rule.* *(3-29-12)*

04. Additional Terms. *The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what direct services must be provided by the agency. The agency's additional terms may be revised or cancelled at any time.* *(5-8-09)*

05. Agency Employees and Subcontractors. *Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency.* *(3-19-07)*

06. Supervision. *The agency must provide staff with adequate case-specific supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. An agency staff person without a Master's degree must be supervised by a licensed master's level professional, as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. PSR agency staff must be supervised in accordance with their applicable status as follows:* *(3-29-12)*

a. *Certified Psychiatric Rehabilitation Practitioners (CPRP) may provide case specific supervision to other CPRP applicants when the supervising CPRP is directly supervised by a Master's level professional defined in Subsection 715.03.* *(3-29-12)*

b. *PSR Specialist applicants who are working toward, or have achieved, the USPRA Certificate in Children's Psychiatric Rehabilitation must be supervised by a licensed master's level professional, as defined in Subsection 715.03.* *(3-29-12)*

c. *The supervisors must ensure that the individual staff members demonstrate adequate competency to work with all populations assigned to them.* *(3-29-12)*

~~**d.** Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)~~

~~**e.** An agency must assure that clinical supervision, as required in the rules of the Idaho Bureau of Occupational Licenses and the Idaho State Board of Medicine, is available to all staff who provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department. (5-8-09)~~

~~**f.** The licensed physician or other licensed practitioner of the healing arts must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed. (5-8-09)~~

~~**07. Staff-to-Participant Ratio**. The following treatment staff-to-participant ratios for group treatment services must be observed: (5-8-09)~~

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

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

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

~~**08. Family Participation Requirement**. The following standards must be observed for services provided to children: (5-8-09)~~

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

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

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

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

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

~~**09. Continuing Education**. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (3-19-07)~~

~~**10. Crisis Service Availability**. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (3-19-07)~~

~~**11. Restraints and Seclusion.** (5-8-09)~~

~~**a.** Restraints and seclusion must not be employed under any circumstances except when an agency staff person employs physical holds as an emergency response to assault or aggression or other immediate safety risks in accordance with the following requirements in Subsections 130.11.a.i. through 130.11.a.iii.: (5-8-09)~~

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

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

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

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

~~**12. Building Standards, Credentialing and Ethics.** All PSR agencies must comply with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712 and Subsection 714.14. PSR agencies whose participants are in the agency building for treatment purposes must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 714.15. (5-8-09)~~

~~**131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): AGENCY STAFF QUALIFICATIONS.** All agency staff delivering direct services must have at least one (1) of the following credentials: (5-8-09)~~

~~**01. Any of the Professions Listed Under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01.** (5-8-09)~~

~~**02. Clinician.** A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources. (5-8-09)~~

~~**03. Psychosocial Rehabilitation (PSR) Specialist.** (5-8-09)~~

~~**a.** Individuals hired as of June 30, 2009, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so until January 1, 2012. In order to continue working as a PSR specialist beyond this date, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**b.** Individuals hired between July 1, 2009, and October 31, 2010, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from their initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. (3-29-12)~~

~~**c.** Individuals hired as of November 1, 2010, who are working as PSR Specialists to deliver Medicaid reimbursable mental health services may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. In order to continue as a PSR Specialist beyond a total period of thirty (30) months, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the USPRA. Such workers must have a bachelor's degree or higher in any field. (3-29-12)~~

i. Credential Required for PSR Specialists Working Primarily with Adults. (3-29-12)

(1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the USPRA requirements. (3-29-12)

(2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (3-29-12)

ii. Credential Required for PSR Specialists Working Primarily with Children. (3-29-12)

(1) Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the USPRA requirements. (3-29-12)

(2) Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (3-29-12)

iii. Classroom Hours. Classroom hours completed for a USPRA credential may be used toward a PSR specialist applicant's continuing education requirements as described in Subsection 130.09 of these rules. The completion of required classroom hours must be documented in the agency's personnel records. (3-29-12)

d. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in the professions identified under Subsections 131.01 through 131.03 of this rule, who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the USPRA credentials. (3-29-12)

132. -- 135. (RESERVED)

136. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): RECORD REQUIREMENTS FOR PROVIDERS.
In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (3-19-07)

01. Name. Name of participant. (3-19-07)

02. Provider. Name of the provider agency and the agency staff person delivering the service. (3-19-07)

03. Date, Time, Duration of Service, and Justification. Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (3-19-07)

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (3-19-07)

05. Treatment Plan Review. A documented outcome-specific review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. These reviews should occur intermittently, but not more than one hundred twenty (120) days apart on a continual basis until the participant is discharged. (3-29-12)

a. A copy of the review must be sent to the Department upon request. Failure to do so may result in a recoupment of reimbursement provided for services delivered after the intermittent staffing review date. (3-29-12)

b. The review must also include a reassessment of the participant's continued need for services. The

review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring changes in the participant's functional impairment. (5-8-09)

c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (3-19-07)

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (3-19-07)

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (3-19-07)

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (3-19-07)

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments for any purpose, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers must comply with Medicaid billing requirements. (5-8-09)

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

137. -- 139. (RESERVED)

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER REIMBURSEMENT.
Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (5-8-09)

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple agency staff are present. (5-8-09)

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)

06. Evaluations and Tests. Evaluations and tests are a reimbursable service if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (5-8-09)

07. Psychiatric or Medical Inpatient Stays. Community reintegration services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the

~~*responsibility of the facility.*~~ ~~*(5-8-09)*~~

~~***08. Reimbursement.***~~ ~~*(3-21-12)*~~

~~***a.*** *For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule.*~~ ~~*(3-21-12)*~~

~~***b.*** *Crisis assistance for adults with serious and persistent mental illness (SPMI) will be paid based on the same reimbursement methodology as service coordination crisis intervention services defined in Subsection 736.09 of these rules.*~~ ~~*(3-21-12)*~~

~~***141. 145. (RESERVED)***~~

~~***146. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): QUALITY OF SERVICES.***~~
~~*The Department must monitor the quality and outcomes of PSR agency services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Behavioral Health.*~~ ~~*(5-8-09)*~~

~~***147.*** ~~**199. (RESERVED)**

(BREAK IN CONTINUITY OF SECTIONS)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-13)

03. Requirements for Collaboration with Other Providers. ~~*(4-4-13)*~~

~~***a.*** When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain

documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the ~~*Psychosocial Rehabilitation (PSR)*~~ outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ~~*(4-4-13)*~~(9-1-13)T

~~***b.*** *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* *(4-4-13)*~~

(BREAK IN CONTINUITY OF SECTIONS)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-13)

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; (7-1-11)

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the

Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-13)

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

d. Therapeutic consultation providers employed by a DDA or the Infant Toddler Program must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-13)

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," by an independent Medicaid provider under agreement with the Department, or by the Infant Toddler Program. Providers of crisis intervention must meet the following minimum qualifications: (7-1-13)

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DD services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA or the Infant Toddler Program on a continuous and regularly scheduled basis. (7-1-13)

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the

necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA and the Infant Toddler Program must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-13)

09. Requirements for Collaboration with Other Providers. ~~(4-4-13)~~

~~**a.**~~ Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ~~(7-1-13)~~(9-1-13)T

~~**b.** *A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition.* (4-4-13)~~

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~(3-19-07)~~(9-1-13)T

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. (5-8-09)

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (5-8-09)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences. or appears to influence the direction of a participant to other services for financial gain. (5-8-09)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

a. Hospitalization; (3-19-07)

b. Loss of housing; (3-19-07)

c. Loss of employment or major source of income; (3-19-07)

d. Incarceration; or (3-19-07)

e. Physical harm to self or others, including family altercation or psychiatric relapse. (3-19-07)

~~***05. High Cost Services**. As used in Subsection 725.01 of these rules, high cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include:* *(3-19-07)*~~

~~***a.** Emergency room visits or procedures;* *(3-19-07)*~~

~~***b.** Inpatient medical and psychiatric services;* *(3-19-07)*~~

~~***c.** Nursing home admission and treatment;* *(3-19-07)*~~

~~***d.** Institutional care in jail or prison;* *(3-19-07)*~~

~~***e.** State, local, or county hospital treatment for acute or chronic illness; and* *(3-19-07)*~~

~~***f.** Outpatient hospital services.* *(3-19-07)*~~

0~~6~~5. **Human Services Field**. A particular area of academic study in health care, social services, education, behavioral science or counseling. (5-8-09)

0~~7~~6. **Paraprofessional**. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (5-8-09)

0~~8~~7. **Person-Centered Planning**. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (5-8-09)

0~~9~~8. **Practitioner of the Healing Arts**. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)

~~1~~09. **Service Coordination**. Service coordination is a case management activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (5-8-09)

~~1~~10. **Service Coordination Plan**. The service coordination plan, also known in these rules as the "plan," includes two components: (5-8-09)

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (5-8-09)

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (5-8-09)

1~~2~~1. **Service Coordination Plan Development**. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (5-8-09)

1~~3~~2. **Service Coordinator**. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (5-8-09)

143. **Supports**. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

724. -- 725. (RESERVED)

~~***725. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.***~~

~~*An adult is eligible for service coordination if he meets the following requirements in Subsections 725.01 through 725.03 of this rule.* (5-8-09)~~

~~***01. Uses High Cost Services**. Is eighteen (18) years of age or older and uses, or has a history of using, high cost medical services associated with periods of increased severity of mental illness.* (5-8-09)~~

~~***02. Diagnosis of Mental Illness**.* (3-19-07)~~

~~***a.** The participant must have undergone a comprehensive diagnostic assessment that meets the definition in Section 111 of these rules. This assessment must be completed by one (1) of the licensed professionals listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.02, and the participant must meet the criteria for:* (5-8-09)~~

~~*i. Serious and Persistent Mental Illness (SPMI) that meets the definition in Section 111 of these rules;* (5-8-09)~~

~~*ii. Delirium dementia, and amnestic disorders; other cognitive disorders; and mental disorders due to a general medical condition; or* (5-8-09)~~

~~*iii. Schizoid, schizotypal, paranoid personality disorders.* (5-8-09)~~

~~***b.** If the only diagnosis is an intellectual disability or is a substance use related disorder, then the person is not included in the target population for mental health service coordination.* (5-8-09)~~

~~***03. Need Assistance**. Have mental illness of sufficient severity to cause a disturbance in their performance or coping skills in at least two (2) of the following areas, on either a continuous (more than one (1) year) or an intermittent (at least once per year) basis:* (5-8-09)~~

~~***a.** Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history.* (3-19-07)~~

~~***b.** Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support himself or manage his finances without assistance.* (3-19-07)~~

~~***c.** Social and interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests.* (3-19-07)~~

~~***d.** Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family.* (3-19-07)~~

~~***e.** Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements.* (3-19-07)~~

~~***f.** Housing: Has lost or is at risk of losing his current residence.* (3-19-07)~~

~~g. Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior, which may result in intervention by law enforcement, the judicial system, or both.~~ ~~(3-19-07)~~

~~h. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens.~~ ~~(3-19-07)~~

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.
To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.0~~5~~3. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination must be made by the Department prior to the initiation of initial and ongoing plan development and services. ~~(7-1-13)~~(9-1-13)T

01. Age. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (5-8-09)

02. Diagnosis. Must ~~be~~ have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts ~~as having one (1) of the diagnoses found in Subsections 726.03 through 726.04 of this rule~~ to prevent or minimize a disability.
~~(7-1-13)~~(9-1-13)T

~~03. Special Health Care Needs. Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability.~~ ~~(3-19-07)~~

~~04. Serious Emotional Disturbance (SED). Have a serious emotional disturbance (SED) with an expected duration of at least one (1) year. The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code.~~ ~~(3-19-07)~~

~~a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and~~ ~~(3-19-07)~~

~~b. Requires sustained treatment interventions; and~~ ~~(3-19-07)~~

~~c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior.~~ ~~(3-19-07)~~

~~d. The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires that the child scores in the "moderate" impairment range in at least two (2) of the subscales. One (1) of the two (2) must be from the following:~~ ~~(5-8-09)~~

~~i. Self-Harmful Behavior;~~ ~~(3-19-07)~~

~~ii. Moods/Emotions; or~~ ~~(3-19-07)~~

~~iii. Thinking.~~ ~~(3-19-07)~~

~~e. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance.~~ ~~(3-19-07)~~

0~~5~~3. Need Assistance. ~~Have one (1) or more of the following problems in Subsection726.05.a. through 726.06.e. of this rule associated with their diagnosis~~ Medicaid-reimbursed service coordination services are not

available for participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems: ~~(7-1-13)~~(9-1-13)T

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (5-8-09)

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (5-8-09)

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (5-8-09)

d. Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)

e. The child requires multiple service providers and treatments. (3-19-07)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed ~~*medical, psychiatric, social, early intervention, educational, and other*~~ services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. ~~(5-8-09)~~(9-1-13)T

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions ~~*to address medical, psychiatric, social, early intervention, educational, and other services*~~ needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. ~~(5-8-09)~~(9-1-13)T

03. Referral and Related Activities. Activities that help link the participant with ~~*medical, psychiatric, social, early intervention, educational providers or other programs and*~~ service~~s~~ providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. ~~(5-8-09)~~(9-1-13)T

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 507 through 515 of these rules. (5-8-09)

~~*c. Crisis Assistance for Adults with Serious and Persistent Mental Illness. Initial crisis assistance is limited to a total of three (3) hours per calendar month. Additional crisis service coordination services must be authorized by the Department and may be requested when the participant is at imminent risk of reinstitutionalization within fourteen (14) days following discharge from a hospital, institution, jail or nursing home, or meets the criteria listed in Subsection 727.05.c.i. through 727.05.c.iii. of this rule;* (5-8-09)~~

~~*i. The participant is experiencing symptoms of psychiatric decompensation that interferes or prohibits the participant from gaining or coordinating necessary services;* (5-8-09)~~

~~*ii. The participant has already received the maximum number of monthly hours of ongoing service coordination and crisis service coordination hours; and* (5-8-09)~~

~~*iii. No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR).* (5-8-09)~~

~~*d.*~~ c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving ~~*either*~~ children's service coordination ~~*or service coordination for adults with mental illness*~~. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. ~~*(5-8-09)*~~(9-1-13)T

09. Limitations on Service Coordination. Service coordination is limited to ~~*the following:* (5-8-09)~~

~~*a. Service Coordination for Persons with Mental Illness. Up to five (5) hours per month of ongoing service coordination for participants with mental illness.* (5-8-09)~~

~~*b. Service Coordination for Children. Up to four and a half (4.5) hours per month for participants who meet the eligibility qualifications for Children's Service Coordination.* (5-8-09)~~

~~*c. Service Coordination for Adults with a Developmental Disability. Up to* four and a half (4.5) hours per month ~~*for participants with developmental disabilities*~~. ~~(5-8-09)~~(9-1-13)T

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours ~~*annually for children, adult participants with mental illness, or adult participants diagnosed with developmental disabilities*~~ per year. ~~(3-29-12)~~(9-1-13)T

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. ~~*All service coordination s*~~Services must be prior authorized by the Department~~*, except the following:*~~ according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. ~~(5-8-09)~~(9-1-13)T

~~*a. Adult mental health service coordination services: service coordination plan development and five (5) hours of ongoing service coordination per month; and the first three (3) hours of crisis service coordination per month. For adults with mental illness, crisis service coordination over three (3) hours per month must be prior authorized.* (5-8-09)~~

~~*b. Children's service coordination services: four and a half (4.5) hours of ongoing service coordination per month.* (5-8-09)~~

02. Service Coordination Plan Development. (5-8-09)

a. A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator ~~*except in the case of adults with serious and persistent mental illness; in which case the time limit is thirty (30) days*~~. ~~(5-8-09)~~(9-1-13)T

b. The plan must be updated at least annually and amended as necessary. (5-8-09)

c. The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. (5-8-09)

d. The plan must be developed prior to ongoing service coordination being provided. (5-8-09)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (3-19-07)

a. The name of the eligible participant. (5-8-09)

b. The name of the provider agency and the person providing the services. (5-8-09)

c. The date, time, duration, and place the service was provided. (5-8-09)

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. (5-8-09)

e. Whether the participant declined any services in the plan. (5-8-09)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (5-8-09)

g. The timeline for obtaining needed services. (5-8-09)

h. The timeline for re-evaluation of the plan. (5-8-09)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (5-8-09)

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (5-8-09)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (5-8-09)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (5-8-09)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian which documents that the participant has been informed of the purposes of service coordination, his rights to refuse service coordination, and his right to choose his service coordinator and other service providers. (5-8-09)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. ~~*Mental health service coordination plans must also be signed by a physician or other practitioner of the healing arts.*~~ The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or his legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. ~~*(5-8-09)*~~(9-1-13)T

~~***04. Documentation of Crisis Assistance for Adults With Serious and Persistent Mental Illness.***~~ ~~*Documentation to support authorization of crisis assistance beyond the monthly limitation must be submitted to the Department before such authorization may be granted. The crisis situation and the crisis service coordination services must be documented in the progress notes of the participant's medical record. Documentation to support delivery of crisis assistance must also be maintained in the participant's agency record and must include:*~~ ~~*(5-8-09)*~~

~~***a.*** *A description of the crisis, including identification of unanticipated events that precipitate the need for crisis service coordination services;*~~ ~~*(5-8-09)*~~

~~***b.*** *A brief review of service coordination and other services or supports available to, or already provided to, the participant to resolve the crisis;*~~ ~~*(5-8-09)*~~

~~***c.*** *A crisis resolution plan; and*~~ ~~*(3-19-07)*~~

~~***d.*** *Outcomes of crisis assistance service provision.*~~ ~~*(3-19-07)*~~

0~~5~~4. **Documentation Completed by a Paraprofessional**. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (5-8-09)

0~~6~~5. **Participant Freedom of Choice**. A participant must have freedom of choice when selecting from the service coordinators available to him. The service coordinator cannot restrict the participant's choice of other health care providers. (5-8-09)

0~~7~~6. **Service Coordinator Contact and Availability**. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At

least every ninety (90) days, ~~the~~ service coordinators must have ~~a~~ face-to-face contact with ~~the~~ each participant ~~except as described in Subsection 728.07.a. of this rule~~. ~~(5-8-09)~~(9-1-13)T

~~a. Mental health service coordinators must have face-to-face contact every month with each participant.~~ ~~(5-8-09)~~

~~b~~a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (5-8-09)

~~c~~b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (5-8-09)

0~~8~~7. **Service Coordinator Responsibility Related to Conflict of Interest**. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: (5-8-09)

a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (5-8-09)

b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (5-8-09)

0~~9~~8. **Agency Responsibility Related to Conflict of Interest**. To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information: (5-8-09)

a. The definition of conflict of interest as defined in Section 721 of these rules; (5-8-09)

b. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and (5-8-09)

c. The participant's, parent's, or legal guardian's signature on the document. (5-8-09)

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (5-8-09)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (5-8-09)

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (5-8-09)

b. That a paraprofessional is not a supervisor. (5-8-09)

03. Agency Supervisor Required Education and Experience. (5-8-09)

a. Master's Degree in a a human services field from a nationally accredited university or college, and

have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

c. Be a licensed professional nurse (RN), and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

~~***d.*** *For mental health service coordination, the supervisor must have obtained the required supervised work experience in a mental health treatment setting with the serious and persistent mentally ill population.* *(5-8-09)*~~

04. Service Coordinator Education and Experience. (5-8-09)

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Be a licensed professional nurse (RN); and have twelve (12) months work experience with the population being served. (5-8-09)

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. (5-8-09)

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (5-8-09)

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (5-8-09)

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (5-8-09)

c. Have twelve (12) months supervised work experience with the population being served. (5-8-09)

06. Limitations on Services Delivered by Paraprofessionals. ~~*(5-8-09)*~~

~~***a.***~~ Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.0~~7~~6 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. ~~*(5-8-09)*~~(9-1-13)T

~~***b.*** *Mental Health Service Coordination does not allow for service provision by paraprofessionals.* *(5-8-09)*~~

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Criminal History and Background Checks." (5-8-09)

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (5-8-09)

730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.

01. Assessment Process. The service coordination assessment must be completed by a service coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant's need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to ensure the child's needs are met. (5-8-09)

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; (5-8-09)

a. Basic needs; (5-8-09)

b. Medical needs; (5-8-09)

c. Health and safety needs; (5-8-09)

d. Therapy needs; (5-8-09)

e. Educational needs; (5-8-09)

f. Social and integration needs; (5-8-09)

g. Personal needs; (5-8-09)

h. Family needs and supports; (5-8-09)

i. Long range planning; (5-8-09)

j. Legal needs; and ~~(5-8-09)~~(9-1-13)T

k. Financial needs~~; and~~. ~~(5-8-09)~~(9-1-13)T

~~***l.*** *For adults with mental illness the comprehensive diagnostic assessment used to establish service coordination eligibility described in Section 725 of these rules* *(5-8-09)*~~

~~***03. Assessment for Mental Health Service Coordination****. The assessment for mental health service coordination must not duplicate the comprehensive diagnostic assessment.* *(5-8-09)*~~

(BREAK IN CONTINUITY OF SECTIONS)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)

a. Service coordination plan development defined in Section 721 of these rules. (5-8-09)

b. Face-to-face contact required in Subsection 728.0~~7~~6 of these rules. ~~(5-8-09)~~(9-1-13)T

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)

i. During the last fourteen (14) days of an inpatient stay which is less than one hundred eighty (180) days in duration; or (5-8-09)

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
82	98	6
97	113	7

(5-8-09)

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

07. Healthy Connections. A participant enrolled in Healthy Connection must receive a referral for assessment and provision of services from his Healthy Connections provider. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. (3-21-12)

08. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)