HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2011 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.03 - RULES GOVERNING EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0203-0901

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in Book 2 of the October 7, 2009, Idaho Administrative Bulletin, Vol. 09-10

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2009.**

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-1003 and 56-1023, Idaho Code.

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

MONDAY, OCTOBER 19, 2009 - 9:00 a.m.

JRW BUILDING, MAIN FLOOR
East Conference Room
700 W. State Street
Boise, Idaho

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:

Senate Bill 1108aa, passed by the 2009 Legislature, makes changes and additions to Title 56, Chapter 10, Idaho Code, that affects the Idaho Emergency Medical Services (EMS) Bureau administrative rules.

This rule change primarily aligns definitions in rule with changes to Idaho Code and replaces old terminology throughout the rule. The provision for nontransport EMS service minimum standards waiver requests is currently in the EMS chapter of rules but will be removed as the waiver provision is now contained in Idaho Statute. Changes in the national standards for EMS personnel eliminated the need for the Emergency Medical Technician-Intermediate (EMT-I) licensure level prior to the implementation of the Idaho EMT-I program. Senate Bill 1108aa removed all references to the EMT-I from Title 56, Chapter 10. References to the EMT-I will therefore be removed from the temporary rule to create consistency in licensure levels with the new statutes.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a and b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: this rulemaking protects the public health, safety, and welfare and must be implemented by July 1, 2009, to ensure compliance with Senate Bill 1108aa passed by the 2009 Legislature.

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

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

This rulemaking has no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the **May 6, 2009, Idaho Administrative Bulletin, Vol. 09-5, page 21**.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Wayne Denny at (208) 334-2085.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 17th day of August, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5564 phone
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0203-0901

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Section 56-10~~17~~23, Idaho Code, to

adopt rules concerning the administration of the Idaho Emergency Medical Services Act. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. ~~(4-6-05)~~(7-1-09)T

001. TITLE AND SCOPE.

01. Scope. These rules include criteria for training programs, certification and licensure of personnel, licensure of ambulance services and nontransport services, licensure of ambulances and nontransport vehicles, establishment of fees for training, inspections, ~~*and*~~ certifications, licensure, and appropriate requirements for ~~*recertification*~~ license renewal of personnel. ~~(7-1-97)~~(7-1-09)T

02. Title. ~~*These rules shall be cited in full as*~~ The title of these rules is IDAPA 16.02.03, ~~*Idaho Department of Health and Welfare,*~~ "~~*Rules Governing*~~ Emergency Medical Services." ~~(7-1-97)~~(7-1-09)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this Bureau has an EMS Standards Manual that contains policy and interpretation of these rules ~~*of this Chapter, or to*~~ and the documentation of compliance with these rules ~~*of this Chapter*~~. Copies of the Standards Manual may be obtained from the EMS Bureau, 650 W. State Street, Suite B-17, Boise, Idaho 83702, P.O. Box 83720, Boise, Idaho 83720-0036. ~~(3-30-01)~~(7-1-09)T

003. ADMINISTRATIVE APPEALS.
All contested cases ~~*shall be*~~ are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(7-1-97)~~(7-1-09)T

(BREAK IN CONTINUITY OF SECTIONS)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (4-6-05)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (4-6-05)

03. Street Address. (7-1-09)T

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ~~(4-6-05)~~(7-1-09)T

b. The EMS Bureau is located at 650 W. State Street, Suite B-17, Boise, Idaho 83702. (7-1-09)T

04. Telephone. (7-1-09)T

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ~~*(4-6-05)*~~(7-1-09)T

b. The telephone number for the EMS Bureau is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. (7-1-09)T

05. Internet Websites. (4-6-05)

a. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. (4-6-05)

b. The Emergency Medical Services Bureau's internet website is found at http://www.idahoems.org. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

007. -- 00~~9~~8. (RESERVED).

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Candidates for initial licensure, as described in Section 501 of these rules, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-09)T

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of these rules, the following terms and abbreviations will be used, as defined below: (7-1-80)

01. Advanced Emergency Medical Technician ~~*Ambulance*~~ (AEMT ~~*A*~~). ~~*An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of an advanced EMT training program, examination, subsequent required continuing training, and recertification.*~~ AEMT is a person who: ~~*(4-6-05)*~~(7-1-09)T

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (7-1-09)T

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-09)T

c. Carries out the practice of emergency care within the scope of practice determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC); and (7-1-09)T

d. Practices under the supervision of a physician licensed in Idaho. (7-1-09)T

02. Advanced Life Support (ALS). The provision of medical care, medication administration and treatment with medical devices ~~*which*~~ that correspond to the knowledge and skill objectives in the ~~*EMT*~~ Paramedic curriculum currently approved by the State Health Officer in accordance with Subsection 201.04 of these rules and within the scope of practice defined in IDAPA ~~*22.01.06, "Rules for EMS Personnel," Subsection 011.05*~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," by persons ~~*certified*~~ licensed as ~~*EMT*~~ Paramedics in accordance with these rules. ~~*(4-5-00)*~~(7-1-09)T

03. Advertise. Communication of information to the public, institutions, or to any person concerned, by any oral, written, or graphic means including handbills, newspapers, television, radio, telephone directories, and billboards. (4-5-00)

04. Agency. ~~*An applicant for designation or a licensed EMS service seeking designation.*~~ Any organization licensed by the EMS Bureau that operates an air medical service, ambulance service, or nontransport service. ~~*(4-5-00)*~~(7-1-09)T

05. Air Ambulance. Any privately or publicly owned fixed wing aircraft or rotary wing aircraft used for, or intended to be used for, the transportation of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code. (7-1-09)T

06. Air Medical Service. An agency licensed by the EMS Bureau that responds to requests for patient care and transportation from hospitals and EMS agencies using a fixed wing aircraft or rotary wing aircraft. (7-1-09)T

0~~5~~7. Air Medical Response. The deployment of an aircraft licensed as an air ambulance to an emergency scene intended for the purpose of patient treatment and transportation. ~~*(4-11-06)*~~(7-1-09)T

0~~6~~8. Ambulance. Any privately or publicly owned ~~*ground*~~ motor vehicle~~,~~ or nautical vessel, ~~*fixed wing aircraft or rotary wing aircraft*~~ used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. This may include dual or multipurpose vehicles that comply with Sections 56-1011 through 56-1023, Idaho Code. ~~*(7-1-97)*~~(7-1-09)T

0~~7~~9. Ambulance-Based Clinicians. Licensed Professional Nurses, Advanced Practice Professional Nurses, and Physician Assistants with current licenses from the Board of Nursing or the Board of Medicine, who are personnel provided by licensed EMS services. (4-5-00)

10. Ambulance Service. An agency licensed by the EMS Bureau operated with the intent to provide personnel and equipment for medical treatment at an emergency scene, during transportation, or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. (7-1-09)T

11. Applicant. Any organization that is requesting an agency license under these rules and includes the following: (7-1-09)T

a. An organization seeking a new license; (7-1-09)T

b. An existing agency that intends to change the level of licensed personnel it utilizes; (7-1-09)T

c. An existing agency that intends to change its geographic coverage area, except by agency annexation; (7-1-09)T

d. An existing nontransport service that intends to provide ambulance service; and (7-1-09)T

e. An existing ambulance service that intends to discontinue transport and become a nontransport service. (7-1-09)T

0812. **Board**. The ***Idaho State*** Board of Health and Welfare. ***(12-31-91)***(7-1-09)T

0913. **Certification**. ***A credential issued to an individual by the EMS Bureau for a specified period of time indicating that minimum standards corresponding to one (1) or several levels of EMS proficiency have been met.*** External verification that an individual has achieved minimum competency to assure safe and effective patient care. ***(7-1-97)***(7-1-09)T

10. Certified Personnel. Individuals who have completed training and successfully passed examinations for training and skills proficiency in one (1) or several levels of emergency medical services. (7-1-97)

1***1***4. **Critical Care Transfer (CCT)**. The transportation of a patient with continuous care, monitoring, medication or procedures requiring knowledge or skills not contained within the ***EMT*** Paramedic curriculum approved by the State Health Officer. Interventions provided by ***EMT*** Paramedics are governed by the scope of practice defined in IDAPA ***22.01.06*** 16.02.02, "***Rules for EMS Personnel*** Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ***(4-6-05)***(7-1-09)T

15. **Commission**. The Idaho Emergency Medical Services Physician Commission (EMSPC). (7-1-09)T

16. **Department**. The Idaho Department of Health and Welfare. (7-1-09)T

1***2***7. **Director**. The Director of the Idaho Department of Health and Welfare or ***designated individual*** his designee. ***(12-31-91)***(7-1-09)T

1***3***8. **Division**. The Idaho Division of Public Health, Department of Health and Welfare. ***(11-19-76)***(7-1-09)T

1***4***9. **Emergency**. A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part.

(4-5-00)

20. **Emergency Medical Responder (EMR)**. A person who: (7-1-09)T

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (7-1-09)T

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-09)T

c. Carries out the practice of emergency care within the scope of practice determined by the Idaho Emergency Medical Services Commission (EMSPC); and (7-1-09)T

d. Practices under the supervision of a physician licensed in Idaho. (7-1-09)T

~~**15**~~**21. Emergency Medical Services (EMS)**. The ~~*services*~~ system utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. ~~*(11-19-76)*~~(7-1-09)T

~~**16**~~**22. EMS Bureau**. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (11-19-76)

~~**17**~~**23. EMS Standards Manual**. A manual published by the EMS Bureau detailing policy information including EMS education, training, certification, licensure, and data collection. (7-1-97)

~~***18. Emergency Medical Technician-Ambulance (EMT-A). A designation issued to an EMT-B by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of supervised in-field experience.*** *(7-1-97)*~~

~~***19. Emergency Medical Technician-Basic (EMT-B). An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a basic EMT training program, examination, subsequent required continuing training, and recertification.*** *(7-1-97)*~~

~~***20. Emergency Medical Technician-Intermediate (EMT-I). An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of an intermediate training program, examination, subsequent required continuing training, and recertification.*** *(4-6-05)*~~

~~***21. Emergency Medical Technician-Paramedic (EMT-P). An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a paramedic training program, examination, subsequent required continuing training, and recertification.*** *(7-1-97)*~~

24. **Emergency Medical Technician (EMT)**. A person who: (7-1-09)T

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023,

Idaho Code, and these rules; (7-1-09)T

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-09)T

c. Carries out the practice of emergency care within the scope of practice determined by the Commission; and (7-1-09)T

d. Practices under the supervision of a physician licensed in Idaho. (7-1-09)T

2~~2~~5. **Emergency Scene**. Any setting (including standbys) outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (4-11-06)

2~~3~~6. **Glasgow Coma Score (GCS)**. A scale used to determine a patient's level of consciousness. It is a rating from three (3) to fifteen (15) of the patient's ability to open his eyes, respond verbally, and move normally. The GCS is used primarily during the examination of patients with trauma or stroke. (4-11-06)

2~~4~~7. **Ground Transport Time**. The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. (4-11-06)

~~*25. First Responder. An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a first responder training program, examination, subsequent required continuing training, and recertification.*~~
~~*(7-1-97)*~~

2~~6~~8. **Licensed EMS Services**. Air medical services, ~~A~~ambulance services and nontransport services licensed by the EMS Bureau to function in Idaho. ~~*(7-1-97)*~~(7-1-09)T

29. **Licensed Personnel**. Those individuals who are Emergency Medical Responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians, and Paramedics. (7-1-09)T

~~27~~30. **Local Incident Management System**. The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. (4-11-06)

31. **National Emergency Medical Services Information System (NEMSIS) Technical Assistance Center**. An organization that validates software for compliance with the EMS data set defined by the United States Department of Transportation National Highway Traffic Safety Administration. (7-1-09)T

~~28~~32. **National Registry of Emergency Medical Technicians (NREMT)**. An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for ~~*certification*~~ licensure.
~~*(7-1-97)*~~(7-1-09)T

~~*29. Non-Transport. A vehicle design or organizational configuration which brings*~~

~~*EMS personnel or equipment to a location, but does not move any sick or injured person from that location.*~~ ~~*(7-1-97)*~~

33. **Nontransport Service**. An agency licensed by the EMS Bureau that is operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but that is not intended to be the service that will actually transport sick or injured persons. (7-1-09)T

34. **Nontransport Vehicle**. Any vehicle that is operated by an agency with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but that is not intended as the vehicle that will actually transport sick or injured persons. (7-1-09)T

3~~0~~5. **Out-of-Hospital**. Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. (4-5-00)

36. **Paramedic**. A person who: (7-1-09)T

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and these rules; (7-1-09)T

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-09)T

c. Carries out the practice of emergency care within the scope of practice determined by the Commission; and (7-1-09)T

d. Practices under the supervision of an physician licensed in Idaho. (7-1-09)T

3~~1~~7. **Patient Assessment**. The evaluation of a patient by EMS ~~*certified*~~ licensed personnel intending to provide treatment or transportation to that patient. ~~*(4-11-06)*~~(7-1-09)T

3~~2~~8. **Physician**. In accordance with Section 54-1803, Idaho Code, ~~A~~a person who holds a current active license~~d~~ issued by the State Board of Medicine to practice medicine ~~*or*~~ and surgery, ~~*or*~~ osteopathic medicine ~~*or*~~ and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. ~~*(11-17-96)*~~(7-1-09)T

3~~3~~9. **Pre-Hospital**. Any setting, ~~(~~including standbys~~)~~, outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. ~~*(4-5-00)*~~(7-1-09)T

~~3~~40. **State Health Officer**. The Administrator of the Division of Public Health. ~~*(11-19-76)*~~(7-1-09)T

41. **Supervision**. The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or nontransport service, including: (7-1-09)T

a. Establishing standing orders and protocols; (7-1-09)T

b. Reviewing performance of licensed personnel; (7-1-09)T

c. Providing instructions for patient care via radio or telephone; and (7-1-09)T

d. Other oversight. (7-1-09)T

~~35~~42. **Transfer**. The transportation of a patient from one (1) medical care facility to another ~~by ambulance~~. ~~(4-5-00)~~(7-1-09)T

011. -- 099. (RESERVED).

100. STATEWIDE EMS ADVISORY COMMITTEE.
The Director will appoint a Statewide EMS Advisory Committee to provide counsel to the Department in administering the EMS Act. The Committee members will have a normal tenure of three (3) years after which time they may be excused or reappointed. However, in order to afford continuity, initial appointments will be made to one-third (1/3) of the membership for two (2) years, one-third (1/3) for three (3) years, and one-third (1/3) of the membership for four (4) years. The Committee chairman will be selected by the State Health Officer. (7-1-97)

01. Committee Membership. The Statewide EMS Advisory Committee will be constituted as follows: (7-1-80)

a. One (1) representative recommended by the State Board of Medicine; ~~and~~ ~~(4-8-94)~~(7-1-09)T

b. One (1) representative recommended by the Idaho Chapter of ACEP; ~~and~~ ~~(4-8-94)~~(7-1-09)T

c. One (1) representative recommended by the Committee on Trauma of the Idaho Chapter of the American College of Surgeons; ~~and~~ ~~(4-8-94)~~(7-1-09)T

d. One (1) representative recommended by the State Board of Nursing; ~~and~~ ~~(4-8-94)~~(7-1-09)T

e. One (1) representative recommended by the Idaho Medical Association; ~~and~~ ~~(4-8-94)~~(7-1-09)T

f. One (1) representative recommended by the Idaho Hospital Association; ~~and~~ ~~(4-8-94)~~(7-1-09)T

g. One (1) representative of local government recommended by the Idaho Association of Counties; ~~and~~ ~~(4-8-94)~~(7-1-09)T

h. One (1) representative of a career third service EMS/Ambulance ~~organization~~ service; ~~and~~ ~~(4-8-94)~~(7-1-09)T

i. One (1) representative of a volunteer third service EMS/Ambulance ~~organization~~

service; ~~and~~ ~~(4-8-94)~~(7-1-09)T

j. One (1) representative of a third service nontransport EMS ~~organization~~ service; ~~and~~ ~~(4-8-94)~~(7-1-09)T

k. One (1) representative of a fire department-based EMS/Ambulance service recommended by the Idaho Fire Chiefs Association; ~~and~~ ~~(4-8-94)~~(7-1-09)T

l. One (1) representative of a fire department-based nontransport EMS ~~organization~~ service; ~~and~~ ~~(4-8-94)~~(7-1-09)T

m. One (1) representative of an air medical ~~EMS organization~~ service; ~~and~~ ~~(7-1-97)~~(7-1-09)T

n. One (1) Emergency Medical Technician ~~Basic~~ who represents the interests of Idaho ~~providers certified~~ personnel licensed at that level; ~~and~~ ~~(4-8-94)~~(7-1-09)T

o. One (1) Advanced Emergency Medical Technician ~~Ambulance~~ who represents the interests of Idaho ~~providers certified~~ personnel licensed at that level; ~~and~~ ~~(7-1-97)~~(7-1-09)T

~~**p.** One (1) Emergency Medical Technician-Intermediate who represents the interests of Idaho providers certified at that level; and (4-6-05)~~

~~**q**~~**p.** One (1) ~~Emergency Medical Technician~~ Paramedic who represents the interests of Idaho ~~providers certified~~ personnel licensed at that level; ~~and~~ ~~(4-8-94)~~(7-1-09)T

~~**r**~~**q.** One (1) representative who is an administrative county EMS director; ~~and~~ ~~(4-8-94)~~(7-1-09)T

~~**s**~~**r.** One (1) EMS instructor who represents the interests of Idaho EMS educators and evaluators; ~~and~~ ~~(4-8-94)~~(7-1-09)T

~~**t**~~**s.** One (1) consumer; ~~and~~ ~~(4-5-00)~~(7-1-09)T

~~**u**~~**t.** One (1) representative of a private EMS transport ~~organization~~ service; ~~and~~ ~~(4-5-00)~~(7-1-09)T

~~**v**~~**u.** One (1) pediatrician who represents the interests of children in the EMS system recommended by the Idaho Chapter of the American Academy of Pediatrics; and (3-30-01)

~~**w**~~**v.** One (1) board certified or equivalent pediatric emergency medicine physician. (3-30-01)

02. Responsibilities of Committee. The EMS Advisory Committee will meet at least annually or as needed for the purposes of: (7-1-80)

a. Reviewing policies and procedures for provision of emergency medical services and recommending same to the ~~Division~~ EMS Bureau; ~~(11-19-76)~~(7-1-09)T

b. Reviewing EMS training curricula, training standards, and examination processes and recommending same to the ~~*Division*~~ EMS Bureau; ~~*(4-8-94)*~~(7-1-09)T

c. Reviewing EMS candidate selection policy and candidate performance requirements and recommending to the ~~*Division*~~ EMS Bureau certification ~~*of*~~ and standards for EMS personnel; ~~*(7-1-97)*~~(7-1-09)T

~~***d.*** *Reviewing and making recommendations for disciplinary action regarding EMS personnel who have not complied with EMS policies;* *(11-19-76)*~~

~~**e**~~**d.** Reviewing and making recommendations on the licensing of ambulance services in Idaho. (11-19-76)

~~***f***~~**e.** Reviewing and making recommendations on the licensing of nontransport services in Idaho. (7-1-97)

101. -- 199. (RESERVED).

200. EMS TRAINING PROGRAMS.
EMS training programs must meet all requirements ~~*in accordance with*~~ under the standards listed in Section 201 of these rules. In order for the EMS Bureau to verify compliance, the course coordinator must submit an application to the EMS Bureau before the course begins. The EMS Training Program may be approved by the EMS Bureau only if all requirements are met. The EMS Training Program must be approved in order for candidates to qualify for access to a certification examination. ~~*(7-1-97)*~~(7-1-09)T

201. STANDARDS.
All initial training programs must be conducted ~~*in accordance with*~~ per the following criteria: ~~*(4-6-05)*~~(7-1-09)T

01. Course Coordinator. Each EMS training program must have a designated course coordinator who has overall responsibility for management of the course and specific duties, including: (4-6-05)

a. Documentation of candidate qualifications, attendance, skill proficiency, and clinical sessions; (7-1-97)

b. Advance scheduling and prior orientation of all other instructors and guest lecturers to the knowledge and skills objectives of the session being taught; (7-1-97)

c. Coordination of access for candidates into health care facilities and licensed EMS services ~~*in accordance with*~~ using the curriculum of the course; ~~*(7-1-97)*~~(7-1-09)T

d. Acquisition of equipment for all skills objectives within the curriculum being taught. (7-1-97)

02. Instructor Qualifications. The course instructor(s) conducting EMS training

courses must meet the appropriate qualifications established in Sections 225 through 230 of these rules. (4-6-05)

03. Physician Oversight. AEMT ~~*A, EMT-I,*~~ and ~~*EMT-*~~Paramedic training courses must be conducted under the direction of a physician. ~~*(4-6-05)*~~(7-1-09)T

04. Curriculum and Equipment. Training courses must use course curricula approved by the State Health Officer and have access to equipment related to all skills objectives within the curricula. (7-1-97)

202. CERTIFICATION EXAMINATIONS.
Certification examinations ~~*shall*~~ will be approved by the State Health Officer and conducted by individuals who are certified or licensed at or above the skill level being examined, or by registered nurses, or by licensed physicians. ~~*(7-1-97)*~~(7-1-09)T

203. MONITORING OF INSTRUCTOR PERFORMANCE.
The EMS Bureau ~~*shall*~~ will monitor instructor performance for all EMS training programs, including candidates' performance on National Registry and other standardized examinations, surveys of candidate satisfaction, and results of other evaluation instruments. Summary findings ~~*shall*~~ will be made available to licensed EMS services and other organizations sponsoring EMS training programs. ~~*(7-1-97)*~~(7-1-09)T

(BREAK IN CONTINUITY OF SECTIONS)

205. CONSISTENCY WITH SCOPE OF PRACTICE.
All curricula approved for use in Idaho or used as the basis for ~~*certification*~~ licensure by a candidate trained elsewhere must be consistent with the scope of practice established by the ~~*Board of Medicine*~~ Commission for the level of ~~*certification*~~ licensure requested by the candidate. ~~*(7-1-97)*~~(7-1-09)T

206. CONSISTENCY WITH NATIONAL STANDARDS.
The EMS Bureau considers the National Standard Curriculum and the National EMS Scope of Practice Model as models for design or adaptation of EMS training program content and EMS ~~*certification*~~ licensure levels. ~~*(4-6-05)*~~(7-1-09)T

207. -- 224. (RESERVED).

225. QUALIFICATIONS OF ~~*FIRST*~~ EMERGENCY MEDICAL RESPONDER COURSE INSTRUCTORS.
~~*First*~~ Emergency Medical Responder Course Instructors must be approved by the EMS Bureau, based on being ~~*certified*~~ licensed for at least three (3) years at or above the level of the session of the curriculum being taught. ~~*(7-1-97)*~~(7-1-09)T

226. QUALIFICATIONS OF EMT-~~*BASIC*~~ COURSE INSTRUCTORS.
EMT-~~*Basic*~~ course instructors must be approved by the EMS Bureau, based on the following

requirements: ~~*(7-1-97)*~~(7-1-09)T

01. Application. Submission of an application to the EMS Bureau; (7-1-97)

02. Adult Instructional Methodology. Completion of one (1) or more courses approved by the EMS Bureau based on content that includes the following instructional methodologies: (4-6-05)

a. The adult learner; (4-6-05)

b. Learning objectives; (4-6-05)

c. Learning process; (4-6-05)

d. Lesson plans; (4-6-05)

e. Course materials; (4-6-05)

f. Preparation; (4-6-05)

g. Teaching aids; (4-6-05)

h. Teaching methods; and (4-6-05)

i. Evaluations. (4-6-05)

03. EMS Instructor Orientation. Completion of the EMS Bureau orientation program for EMS instructors or equivalent; and (4-6-05)

04. ~~*Certification*~~ Licensure. ~~*Certification*~~ Licensure at or above the level of curriculum being taught, for at least three (3) years. Licensed individuals and other health care providers must also be ~~*certified*~~ licensed at the EMT level. ~~*(7-1-97)*~~(7-1-09)T

227. PRIMARY OR LEAD EMT~~*-BASIC*~~ INSTRUCTORS.
Primary or lead instructors must be approved as EMT~~*-Basic*~~ Course Instructors, personally instruct at least seventy-five percent (75%) of the didactic training of the course, and instruct or oversee the skills training in the curriculum. ~~*(4-6-05)*~~(7-1-09)T

228. EMT~~*-BASIC*~~ SKILLS INSTRUCTORS.
EMT~~*-Basic*~~ skills instructors ~~*shall*~~ must be approved as EMT~~*-Basic*~~ Course Instructors and shall personally instruct the psychomotor portions of the curriculum. ~~*(7-1-97)*~~(7-1-09)T

229. ADVANCED EMT AND ~~*EMT-*~~PARAMEDIC INSTRUCTORS.
AEMT~~*-A*~~ and ~~*EMT-*~~Paramedic Instructors must be approved by the EMS Bureau based on having credentials, education or experience that correspond to the knowledge and skills objectives being taught. ~~*(7-1-97)*~~(7-1-09)T

~~***230. EMT INTERMEDIATE INSTRUCTORS.***~~

~~*All EMT-I primary or lead instructors must meet the following criteria:* (4-6-05)~~

~~***01. Certification**. One (1) of the following must be documented:* (4-6-05)~~

~~***a.** Three (3) or more years of certification at or above the EMT-I level;* (4-6-05)~~

~~***b.** Idaho licensure as a physician, licensed professional nurse or other mid-level health care provider, and current certification at any EMS provider level;* (4-6-05)~~

~~***c.** Employment as an instructor by a college or university and teaching an accredited paramedic program.* (4-6-05)~~

~~***02. Adult Instructional Methodology**. Completion of one (1) or more courses approved by the EMS Bureau based on content as listed in Subsection 226.02 of these rules.* (4-6-05)~~

~~***03. EMS Instructor Orientation**. Completion of an EMS Bureau orientation program for EMS instructors, or equivalent, within eighteen (18) months of the proposed course start date or instructor application submission.* (4-6-05)~~

~~***04. Application**. Submission of an application to the EMS Bureau documenting credentials, education or experience that correspond to the knowledge and skills objectives being taught.* (4-6-05)~~

~~***05. Bureau Approval**. Approval will be verified for every primary or lead EMT-Intermediate instructor listed on each EMT-Intermediate course application.* (4-6-05)~~

~~***06. Primary or Lead Instructors**. Primary or lead instructors must personally instruct or monitor at least ninety percent (90%) of the didactic training of the course, and must instruct or oversee the skills training in the curriculum.* (4-6-05)~~

23~~1~~0. -- 299. (RESERVED).

300. AMBULANCE SERVICE STANDARDS.
To qualify for licensing as an ambulance service under Section 56-1016, Idaho Code, the applicant must demonstrate compliance with the following: (4-6-05)

01. Ambulance Vehicles. All ambulance and air ambulance vehicles must meet one (1) of the following conditions to be licensed: ~~(4-6-05)~~(7-1-09)T

a. The vehicle meets or exceeds any federal, industry, or trade specifications or standards for ambulance and air ambulance vehicles as identified by the applicant. ~~(7-1-97)~~(7-1-09)T

b. The vehicle has been uniquely configured or modified to meet specialized needs and has been inspected and approved by the EMS Bureau. (7-1-97)

02. Required Ambulance and Air Ambulance Equipment. Each ambulance must

be equipped with the following: ~~*(7-1-97)*~~(7-1-09)T

a. Medical care supplies and devices as specified in the Minimum Equipment Standards for Licensed EMS Services. Exceptions to the minimum equipment requirements may be granted by the EMS Bureau upon inspection, when the circumstances and available alternatives assure that appropriate patient care will be provided for all foreseeable incidents. (7-1-97)

b. Mobile radio on 155.340 MHZ and 155.280 MHZ frequencies with encoding capabilities to allow access to the Idaho EMS radio communications system; and (11-19-76)

c. Safety equipment and personal protective supplies for ~~*certified*~~ licensed personnel and other vehicle occupants as specified in the Minimum Equipment Standards, including materials to provide for body substance isolation and protection from exposure to communicable diseases and pathogens under Section 56-1017, Idaho Code. ~~*(4-6-05)*~~(7-1-09)T

03. Ambulance Personnel. The ambulance service must demonstrate that a sufficient number of personnel are affiliated with the service to accomplish a twenty-four (24) hour a day, seven (7) day a week response capability in accordance with Section 56-1016, Idaho Code. The service must describe its anticipated staffing patterns per vehicle and shift on the application supplied by the EMS Bureau. The annual inspection by the EMS Bureau must include a review of the ambulance service personnel staffing configuration. (4-6-05)

04. Records to be Maintained. The ambulance service must maintain records of each ambulance and air ambulance response and submit them to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: ~~*(7-1-97)*~~(7-1-09)T

a. Name of ambulance service; and (11-19-76)

b. Date of response; and (7-1-97)

c. Time call received; and (11-19-76)

d. Time en route to scene; and (7-1-97)

e. Time arrival at scene; and (11-19-76)

f. Time service departed scene; and (7-1-97)

g. Time arrival at hospital; and (11-19-76)

h. Location of incident; and (11-19-76)

i. Description of illness/injury; and (11-19-76)

j. Description of patient management; and (11-19-76)

k. Patient destination; and (11-19-76)

l. Ambulance unit identification; and (11-19-76)

m. Identification and ~~*certification*~~ licensure level of each ambulance crew member on the response; and ~~*(7-1-97)*~~(7-1-09)T

n. Response outcome. (7-1-97)

05. Communications. Ambulance service dispatch must be in accordance with Section 56-1016, Idaho Code. The application for licensure must describe the radio, telephonic, or other electronic means by which patient care instructions from an authorized medical source will be obtained. The annual inspection by the EMS Bureau will include a review of the ambulance service dispatch and communications configuration. (4-6-05)

06. Medical Control Plan. The ambulance service must describe the extent and type of supervision by a licensed physician that is available to ~~*certified*~~ licensed personnel. The annual inspection by the EMS Bureau will include a review of the ambulance service medical control configuration. ~~*(4-6-05)*~~(7-1-09)T

07. Medical Treatment Protocols. The ambulance service must submit a complete copy of the medical treatment protocols and written standing orders under which its ~~*certified*~~ licensed personnel will function with the application for licensure. ~~*(4-6-05)*~~(7-1-09)T

08. Training Facility Access. The applicant must describe the arrangements which will provide access to clinical and didactic training locations, in the initial application for service licensure. (4-6-05)

09. Geographic Coverage Description. Each application for initial licensure must contain a specific description of the Idaho jurisdiction(s) that the ambulance service will serve using known geopolitical boundaries or geographic coordinates. (4-6-05)

10. Required Application. The applicant must submit a completed application to the EMS Bureau to be considered for licensure. The most current standardized form will be available from the EMS Bureau. An additional application may be required prior to subsequent annual inspection by the EMS Bureau. (4-6-05)

11. Inspection. Representatives of the EMS Bureau are authorized to enter the applicant's facility or other location as designated by the applicant at reasonable times, for the purpose of inspecting the ambulance services' vehicle(s) and equipment, ambulance and air ambulance response records, and other necessary items to determine eligibility for licensing by the state of Idaho in relation to the minimum standards in Section 56-1016, Idaho Code. ~~*(4-6-05)*~~(7-1-09)T

12. License. Ambulance services must be licensed on an annual basis by the EMS Bureau. (7-1-97)

301. NONTRANSPORT SERVICE STANDARDS.

In order to qualify for licensing as a nontransport service under Section 56-1016, Idaho Code, the applicant must demonstrate compliance with the following: (4-6-05)

01. Vehicles. All vehicles must meet one (1) of the following conditions to be licensed: (7-1-97)

a. The vehicle meets or exceeds standards for that type vehicle, including federal, industry, or trade specifications, as identified by the applicant and recognized and approved by the EMS Bureau. (7-1-97)

b. The vehicle has been uniquely configured or modified to meet specialized needs and has been inspected and approved by the EMS Bureau. (7-1-97)

02. Required Equipment for Nontransport Services. ~~*Certified*~~ Licensed personnel must have access to required equipment. The equipment must be stored on a dedicated response vehicle, or in the possession of ~~*certified*~~ licensed personnel. The application for licensure as a nontransport service must include a description of the following: ~~*(4-6-05)*~~(7-1-09)T

a. Medical care supplies and devices as specified in the Minimum Equipment Standards for Licensed EMS Services. Exceptions to the minimum equipment requirements may be granted by the EMS Bureau upon inspection, when the circumstances and available alternatives assure that appropriate patient care will be provided for all foreseeable incidents. (7-1-97)

b. Mobile or portable radio(s) on 155.340 MHZ and 155.280 MHZ frequencies with encoding capabilities to allow access to the Idaho EMS radio communications system; and (7-1-97)

c. Safety equipment and personal protective supplies for ~~*certified*~~ licensed personnel and other vehicle occupants as specified in the Minimum Equipment Standards for Licensed EMS Services, including materials to provide for body substance isolation and protection from exposure to communicable diseases under Section 56-10~~17~~23, Idaho Code. ~~*(4-6-05)*~~(7-1-09)T

03. Nontransport Service Personnel. The nontransport service must demonstrate that a sufficient number of ~~*certified*~~ licensed personnel are affiliated with the service to accomplish a twenty-four (24) hour a day, seven (7) day a week response capability. Exceptions to this requirement may be granted by the EMS Bureau when strict compliance with the requirement would cause undue hardship on the community being served, or would result in abandonment of the service. The annual inspection by the EMS Bureau will include a review of the personnel staffing configuration. ~~*(4-6-05)*~~(7-1-09)T

04. Records to Be Maintained. The nontransport service must maintain records of each EMS response in a form approved by the EMS Bureau. ~~*that include at least the following information:*~~ All applicant nontransport services who submit an application to the EMS Bureau after July 1, 2009, must submit records of each EMS response to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: ~~*(7-1-97)*~~(7-1-09)T

a. Identification of nontransport service; ~~and~~ ~~(7-1-97)~~(7-1-09)T

b. Date of response; ~~and~~ ~~(7-1-97)~~(7-1-09)T

c. Time call received; ~~and~~ ~~(7-1-97)~~(7-1-09)T

d. Time en route to scene; ~~and~~ ~~(7-1-97)~~(7-1-09)T

e. Time arrival at scene; ~~and~~ ~~(7-1-97)~~(7-1-09)T

f. Time service departed scene; ~~and~~ ~~(7-1-97)~~(7-1-09)T

g. Location of incident; ~~and~~ ~~(7-1-97)~~(7-1-09)T

h. Description of illness/injury; ~~and~~ ~~(7-1-97)~~(7-1-09)T

i. Description of patient management; ~~and~~ ~~(7-1-97)~~(7-1-09)T

j. Patient destination; ~~and~~ ~~(7-1-97)~~(7-1-09)T

k. Identification and licensure level of nontransport service personnel on response ~~and certification~~; and ~~(7-1-97)~~(7-1-09)T

l. Response outcome. (7-1-97)

05. Communications. The application for licensure must describe the radio, telephonic, or other electronic means by which patient care instructions from an authorized medical source will be obtained. The annual inspection by the EMS Bureau will include a review of the nontransport service dispatch and communications configuration. (4-6-05)

06. Medical Control Plan. The nontransport service must describe the extent and type of supervision by a licensed physician that is available to ~~certified~~ licensed personnel. The annual inspection by the EMS Bureau will include a review of the nontransport service medical control configuration. ~~(4-6-05)~~(7-1-09)T

07. Medical Treatment Protocols. The nontransport service must submit a complete copy of the medical treatment protocols and written standing orders under which its ~~certified~~ licensed personnel will function with the initial application for licensure. ~~(4-6-05)~~(7-1-09)T

08. Training Facility Access. The applicant must describe the arrangements which will provide access to clinical and didactic training locations in the initial application for service licensure. (4-6-05)

09. Geographic Coverage Description. Each application for initial licensure must contain a specific description of the Idaho jurisdiction(s) that the nontransport service will serve using known geopolitical boundaries or geographic coordinates. (4-6-05)

10. Required Application. The applicant must submit a completed application to the

EMS Bureau to be considered for licensure. The most current standardized form is available from the EMS Bureau. An additional application may be required prior to subsequent annual inspection by the EMS Bureau. (4-6-05)

11. Inspection. Representatives of the Department are authorized to enter the applicant's facility or other location as designated by the applicant at reasonable times, for the purpose of inspecting the nontransport services' vehicle(s) and equipment, nontransport response records, and other necessary items to determine eligibility for licensing by the state of Idaho. (7-1-97)

~~***12. Nontransport Service Minimum Standards Waiver**. The controlling authority providing nontransport services may petition the EMS Bureau for waiver of the nontransport service standards of these rules, if compliance with the service standards would cause undue hardship on the community being served. (7-1-97)***~~

1~~3~~2. License. Nontransport services must be licensed on an annual basis by the EMS Bureau. (7-1-97)

302. -- 319. (RESERVED).

320. DESIGNATION OF CLINICAL CAPABILITY.
All ambulance and nontransport licenses issued by the EMS Bureau must indicate the clinical level of service which can be provided by the ambulance or nontransport service after verification of compliance with Section 300 or Section 301 of these rules. Agencies which provide ~~*certified*~~ licensed personnel at the ~~*First Responder,*~~ EMR or EMT~~*-B, or EMT-A*~~ level will be designated as Basic Life Support services. Agencies which provide ~~*certified*~~ licensed personnel at the AEMT~~*-A or EMT-Intermediate*~~ level will be designated as Intermediate Life Support services. Designation of services which function at or above the ALS level will be issued ~~*in accordance with*~~ under Section 340 of these rules. Licensed EMS Services may function at one (1) or more ALS levels corresponding to the designation issued by the EMS Bureau as a result of the application and inspection process required in Sections 300 and 301 of these rules. ~~*(4-6-05)*~~(7-1-09)T

321. -- 32~~3~~4. (RESERVED).

~~***324. STANDARDS FOR AGENCIES UTILIZING EMT INTERMEDIATE PERSONNEL.***~~
~~*An agency which has demonstrated compliance with Section 300 or Section 301 of these rules may qualify to utilize EMT-Intermediate personnel if the following criteria are met: (4-6-05)*~~

~~***01. Personnel**. The agency must have one (1) or more EMT-Intermediates listed on the agency personnel roster. The agency is specifically prohibited from utilizing other licensed health care providers unless they are accompanied by or are cross-trained and certified as an EMS provider. (4-6-05)***~~

~~***a.** EMT-Intermediate personnel must hold current certification issued by the EMS Bureau in accordance with Sections 501 and 510 of these rules. (4-6-05)*~~

~~***b.** An agency may use Ambulance-Based Clinicians who function with an EMT-I or are cross-trained and certified as an EMT-I. The agency must verify that all Ambulance-Based*~~

~~*Clinicians have successfully completed a formal training program of pre-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board.* (4-6-05)~~

~~***c.*** *Personnel must initiate intermediate life support as authorized by the physician designated as the medical director of the agency, and other physicians providing on-line medical direction as specified in IDAPA 22.01.06, "Rules for EMS Personnel."* (4-6-05)~~

~~***d.*** *Personnel must initiate requests for on-line medical direction as dictated by the EMS agency's protocols.* (4-6-05)~~

~~***02. Required Documentation****. The affiliation status and ongoing proficiency maintenance of the certified personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau.* (4-6-05)~~

~~***a.*** *The agency must submit a roster of all certified personnel and Ambulance-Based Clinicians with the initial and renewal application for licensure.* (4-6-05)~~

~~***b.*** *The agency must maintain documentation of proficiency assurance of all certified personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of certification.* (4-6-05)~~

~~***03. Required Equipment****. The agency vehicle(s) must be equipped with the minimum required equipment listed in the EMT-Intermediate Services section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau.* (4-6-05)~~

325. PRE-HOSPITAL ADVANCED LIFE SUPPORT (ALS) STANDARDS.
Pre-hospital ALS designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities which are within the scope of practice established under IDAPA ~~*22.01.06*~~ 16.02.02, ~~*"Rules for EMS Personnel," Subsection 011.05,*~~ "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," for the purposes of responding to emergencies in any 911 service area, standby, or other area on an emergency basis. Designation is for the same duration as the license issued to the EMS agency. An agency which has demonstrated compliance with Section 300 or Section 301 of these rules may qualify for Pre-hospital ALS designation if the following criteria are met: ~~*(4-6-05)*~~(7-1-09)T

01. Personnel. The agency must have a sufficient number of ~~*EMT*~~ Paramedics to assure availability of such personnel corresponding to the anticipated call volume of the agency. The agency is specifically prohibited from utilizing other licensed health care providers for pre-hospital and emergency responses to requests for EMS unless they are accompanied by or cross-trained and ~~*certified*~~ licensed as a~~*n EMT*~~ Paramedic. ~~*(4-5-00)*~~(7-1-09)T

a. ~~*EMT*~~ Paramedic personnel must hold a current ~~*certification*~~ license issued by the EMS Bureau ~~*in accordance with*~~ under Sections 501 and 510 of these rules. ~~*(4-5-00)*~~(7-1-09)T

b. An agency may use Ambulance-Based Clinicians who function with a~~n EMT~~ Paramedic or are cross-trained and ~~certified~~ licensed as a~~n EMT~~ Paramedic. The agency must verify that all Ambulance-Based Clinicians have successfully completed a formal training program of pre-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency ~~shall~~ must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board. ~~(4-6-05)~~(7-1-09)T

c. Personnel must initiate advanced life support as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical ~~direction~~ supervision as specified in IDAPA ~~22.01.06~~ 16.02.02, "~~Rules for EMS Personnel,~~ Rules of the Idaho Emergency Medical Services (EMS) Physician Commission" ~~Subsection 011.05~~.
~~(4-6-05)~~(7-1-09)T

02. Required Documentation. The employment status and ongoing proficiency maintenance of the ~~certified~~ licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau. ~~(4-5-00)~~(7-1-09)T

a. The agency must submit a roster of all ~~certified~~ licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change. ~~(4-5-00)~~(7-1-09)T

b. The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all ~~certified~~ licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period. ~~(4-5-00)~~(7-1-09)T

03. Required Equipment. The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau. (4-6-05)

04. Administrative License Action. A pre-hospital ALS designation may be suspended or revoked in accordance with Section 515 of these rules. The agency is specifically prohibited from advertising as or responding to requests for critical care transfer service unless the agency also holds Critical Care Transfer Service designation ~~in accordance with~~ under Section 335 of these rules. ~~(4-5-00)~~(7-1-09)T

326. -- 329. (RESERVED).

330. ADVANCED LIFE SUPPORT (ALS) TRANSFER STANDARDS.
ALS Transfer designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities which are within the scope of practice established under IDAPA ~~22.01.06~~ 16.02.02, "~~Rules for EMS Personnel~~ Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," ~~Subsection 011.05,~~ for the purposes of providing medical care and transportation between medical care facilities. Designation is for the same duration as the license issued to the EMS agency. An agency which

has demonstrated compliance with Section 300 or Section 301 of these rules may qualify for ALS Transfer designation if the following criteria are met: ~~(4-6-05)~~(7-1-09)T

01. Personnel. The agency must have a sufficient number of personnel to assure availability corresponding to the anticipated call volume of the agency. (4-5-00)

a. ~~EMT~~ Paramedic personnel must hold a current ~~certification~~ license issued by the EMS Bureau ~~in accordance with~~ under Sections 501 and 510 of these rules. ~~(4-5-00)~~(7-1-09)T

b. An agency which will advertise or provide ALS transfer of patients may use Ambulance-Based Clinicians as the medical care provider for those patients. The agency ~~shall~~ must verify that all Ambulance-Based Clinicians have successfully completed a formal training program of out-of-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency ~~shall~~ must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board. ~~(4-5-00)~~(7-1-09)T

c. Personnel ~~shall~~ will initiate advanced life support as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical ~~direction~~ supervision as specified in IDAPA ~~22.01.06~~ 16.02.02, "~~Rules for EMS Personnel,~~ Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~Subsection 011.05.~~ ~~(4-5-00)~~(7-1-09)T

02. Required Documentation. The employment status and ongoing proficiency maintenance of the ~~certified~~ licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau. ~~(4-5-00)~~(7-1-09)T

a. The agency must submit a roster of all ~~certified~~ licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change. ~~(4-5-00)~~(7-1-09)T

b. The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all ~~certified~~ licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period. ~~(4-5-00)~~(7-1-09)T

03. Required Equipment. The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau. (4-6-05)

04. Administrative License Action. An ALS Transfer designation may be suspended or revoked in accordance with Section 515 of these rules. The agency is specifically prohibited from advertising or responding to pre-hospital and emergency requests for ALS unless the agency also holds pre-hospital ALS designation in accordance with Section 325 of these rules. The agency is specifically prohibited from advertising as or responding to requests for critical care transfer service unless the agency also holds Critical Care Transfer Service designation in

accordance with Section 335 of these rules. (4-5-00)

331. -- 334. (RESERVED).

335. CRITICAL CARE TRANSFER SERVICE STANDARDS.
Critical Care Transfer Service designation of an agency by the EMS Bureau is required for any agency which will advertise or supply clinical personnel and equipment capabilities requiring knowledge or skills not contained within the ~~*EMT-*~~Paramedic curriculum approved by the State Health Officer. Designation shall be for the same duration as the license issued to the EMS agency. An agency which has demonstrated compliance with Section 300 of these rules may qualify for Critical Care Transfer Service designation if the following criteria are met:
~~*(4-5-00)*~~(7-1-09)T

01. Personnel. The agency must have a sufficient number of personnel to assure availability corresponding to the anticipated call volume of the agency. (4-5-00)

a. ~~*EMT-*~~Paramedic personnel must hold current ~~*certification*~~ license issued by the EMS Bureau in accordance with Sections 501 and 510 of these rules. All ~~*EMT-*~~Paramedics who will be the primary or the only care provider during critical care transfers must have successfully completed a formal training program in critical care transport which meets or exceeds the objectives of the curriculum approved by the State Health Officer. ~~*(4-5-00)*~~(7-1-09)T

b. An agency which will advertise or provide ALS transfer of patients may use Ambulance-Based Clinicians as the medical care provider for those patients. The agency ~~*shall*~~ must verify that all Ambulance-Based Clinicians have successfully completed a formal training program of out-of-hospital medical care which meets or exceeds the objectives of the curriculum approved by the State Health Officer. The agency ~~*shall*~~ must assure that any Ambulance-Based Clinicians meet additional requirements of the corresponding licensing board. ~~*(4-5-00)*~~(7-1-09)T

c. Personnel ~~*shall*~~ will initiate critical care as authorized by the physician designated as the Medical Director of the agency, and other physicians providing on-line medical ~~*direction*~~ supervision as specified in IDAPA ~~*22.01.06*~~ 16.02.02, "~~*Rules for EMS Personnel,*~~ Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~*Subsection 011.05.*~~
~~*(4-5-00)*~~(7-1-09)T

02. Required Documentation. The employment status and ongoing proficiency maintenance of the ~~*certified*~~ licensed personnel and Ambulance-Based Clinicians associated with the agency must be documented on a periodic basis to the EMS Bureau. ~~*(4-5-00)*~~(7-1-09)T

a. The agency must submit a roster of all ~~*certified*~~ licensed personnel and Ambulance-Based Clinicians with the application for licensure. Any change in the roster due to attrition or hiring must be documented to the EMS Bureau in writing within sixty (60) calendar days of the change. ~~*(4-5-00)*~~(7-1-09)T

b. The agency must maintain documentation of continuing education, refresher courses, and proficiency assurance of all ~~*certified*~~ licensed personnel and Ambulance-Based Clinicians in accordance with the EMS Standards Manual in effect at the time of designation and any EMS Standards Manual which takes effect during the designation period. ~~*(4-5-00)*~~(7-1-09)T

03. Required Equipment. The agency vehicle(s) must be equipped with the Minimum Required Equipment listed in the ALS section of the Minimum Equipment Standards incorporated in these rules. The agency must disclose all additional medical equipment routinely carried on the agency vehicle(s) not included in the Minimum Equipment Standards in the application provided by the EMS Bureau. (4-6-05)

04. Administrative License Action. A Critical Care Transfer Service designation may be suspended or revoked in accordance with Section 515 of these rules. The agency is specifically prohibited from advertising or responding to pre-hospital and emergency requests for ALS unless the agency also holds pre-hospital ALS designation in accordance with Section 325 of these rules. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

400. ADVANCE DO NOT RESUSCITATE DIRECTIVES.

01. Protocols. (11-10-94)

a. The EMS Advisory Committee will establish standard protocols for EMS personnel to respond to advance DNR directives. (11-10-94)

b. The protocol will be reviewed at least annually by the EMS Advisory Committee to determine if changes in protocol should be made to reflect technological advances. (11-10-94)

c. The Department will notify Idaho EMS ~~*providers*~~ personnel of DNR protocols and any subsequent changes. ~~*(11-10-94)*~~(7-1-09)T

02. Do Not Resuscitate Order. (11-10-94)

a. A standard DNR form will be made available to physicians by the Department or its designee. (11-10-94)

b. One (1) copy will be maintained in the patient's file and one (1) copy will be kept by the patient. (11-10-94)

03. Do Not Resuscitate Identification. (11-10-94)

a. Only a physician signed DNR order or a Department approved bracelet or necklace will be honored by EMS personnel. (11-10-94)

b. The bracelet or necklace will have an easily identifiable logo that solely represents a DNR code. (11-10-94)

c. The Department will advise EMS personnel of what constitutes an acceptable

identification. (11-10-94)

d. No DNR identification may be issued without a valid DNR order in place. (11-10-94)

e. Only vendors authorized by the Department may sell or distribute DNR identifications. (11-10-94)

401. -- 404. (RESERVED).

405. STANDARDS FOR THE APPROPRIATE USE OF AIR MEDICAL AGENCIES BY ~~*CERTIFIED*~~ LICENSED EMS PERSONNEL AT EMERGENCY SCENES.

01. Who Establishes Training Curricula and Continuing Education Requirements for Air Medical Criteria? The EMS Bureau will incorporate education and training regarding the air medical criteria established in Section 425 of this rule into initial training curricula and required continuing education of ~~*certified*~~ licensed EMS personnel. ~~*(4-11-06)*~~(7-1-09)T

02. Who Must Establish Written Criteria Guiding Decisions to Request an Air Medical Response? Each licensed EMS service must establish written criteria, approved by the EMS service medical director, to guide the decisions of the service's ~~*certified*~~ licensed EMS personnel to request an air medical response to an emergency scene. The criteria will include patient conditions found in Section 415 of these rules. ~~*(4-11-06)*~~(7-1-09)T

03. What Written Criteria is Required for EMS Service Licensure? Written criteria guiding decisions to request an air medical response will be required for all initial and renewal applications for EMS service licensure for licenses effective on November 1, 2006, or later. (4-11-06)

04. Who Is Responsible for Requesting an Air Medical Response? ~~*Certified*~~ Licensed EMS personnel en route to or at the emergency scene have the primary responsibility and authority to request the response of air medical services ~~*in accordance with*~~ using the local incident management system and licensed EMS service written criteria. ~~*(4-11-06)*~~(7-1-09)T

05. When Can ~~*Certified*~~ Licensed EMS Personnel Cancel an Air Medical Response? ~~*Certified*~~ Licensed EMS personnel must complete a patient assessment prior to their cancellation of an air medical response. ~~*(4-11-06)*~~(7-1-09)T

06. Who May Establish Criteria for Simultaneous Dispatch? The licensed EMS service may establish criteria for simultaneous dispatch for air and ground medical response. Air medical services will not respond to an emergency scene unless requested. (4-11-06)

07. Who Is Responsible for Selecting an Appropriate Air Medical Service? Selection of an appropriate air medical service is the responsibility of the licensed EMS service. (4-11-06)

a. The licensed EMS service, through written policy, will establish a process of air

medical selection. (4-11-06)

b. The written policy must direct EMS personnel to honor a patient request for a specific air medical service when the circumstances will not jeopardize patient safety or delay patient care. (4-11-06)

406. -- 414. (RESERVED).

415. AIR MEDICAL RESPONSE CRITERIA.
The need for an air medical request will be determined by the licensed EMS service ~~*certified*~~ licensed personnel based on their patient assessment and transport time. Each licensed EMS service must develop written criteria based on best medical practice principles. The following conditions must be included in the criteria: ~~*(4-11-06)*~~(7-1-09)T

01. What Clinical Conditions Require Written Criteria? The licensed EMS service written criteria will provide guidance to the ~~*certified*~~ licensed EMS personnel for the following clinical conditions: ~~*(4-11-06)*~~(7-1-09)T

a. The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis; (4-11-06)

b. Neurological presentation suggestive of spinal cord injury; (4-11-06)

c. Evidence of a skull fracture (depressed, open, or basilar) as detected visually or by palpation; (4-11-06)

d. Fracture or dislocation with absent distal pulse; (4-11-06)

e. A Glasgow Coma Score of ten (10) or less; (4-11-06)

f. Unstable vital signs with evidence of shock; (4-11-06)

g. Cardiac arrest; (4-11-06)

h. Respiratory arrest; (4-11-06)

i. Respiratory distress; (4-11-06)

j. Upper airway compromise; (4-11-06)

k. Anaphylaxis; (4-11-06)

l. Near drowning; (4-11-06)

m. Changes in level of consciousness; (4-11-06)

n. Amputation of an extremity; and (4-11-06)

o. Burns greater than twenty percent (20%) of body surface or with suspected airway compromise. (4-11-06)

02. What Complicating Conditions Require Written Criteria? When associated with clinical conditions in Subsection 415.01 of these rules, the following complicating conditions require written guidance for EMS personnel: (4-11-06)

a. Extremes of age; (4-11-06)

b. Pregnancy; and (4-11-06)

c. Patient "do not resuscitate" status as described in Section 400 of these rules. (4-11-06)

03. What Operational Conditions Require Written Guidance for an Air Medical Response? The licensed EMS service written criteria will provide guidance to the ~~*certified*~~ licensed EMS personnel for the following operational conditions: ~~*(4-11-06)*~~(7-1-09)T

a. Availability of local hospitals and regional medical centers; (4-11-06)

b. Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time; (4-11-06)

c. Access to time sensitive medical interventions such as percutaneous coronary intervention, thrombolytic administration for stroke, or cardiac care; (4-11-06)

d. When the patient's clinical condition indicates the need for advanced life support and air medical is the most readily available access to advanced life support capabilities; (4-11-06)

e. As an additional resource for a multiple patient incident; (4-11-06)

f. Remote location of the patient; and (4-11-06)

g. Local destination protocols. (4-11-06)

(BREAK IN CONTINUITY OF SECTIONS)

425. LANDING ZONE AND SAFETY.

01. Who Is Responsible for Setting Up Landing Zone Procedures? The licensed EMS service in conjunction with the air medical service(s) must have written procedures for establishment of landing zones. Such procedures will be compatible with the local incident management system. (4-11-06)

02. What Are the Responsibilities of Landing Zone Officers? The procedures for establishment of landing zones must include identification of Landing Zone Officers with responsibility for the following: (4-11-06)

a. Landing zone preparation; (4-11-06)

b. Landing zone safety; and (4-11-06)

c. Communication between ground and air agencies. (4-11-06)

03. What Training Is Required for Landing Zone Officers? The licensed EMS service will assure that EMS ~~*certified*~~ licensed personnel, designated as Landing Zone Officers, have completed training in establishing an air medical landing zone based on the following elements: ~~*(4-11-06)*~~(7-1-09)T

a. The required size of a landing zone; (4-11-06)

b. The allowable slope of a landing zone; (4-11-06)

c. The allowable surface conditions; (4-11-06)

d. Hazards and obstructions; (4-11-06)

e. Marking and lighting; (4-11-06)

f. Landing zone communications; and (4-11-06)

g. Landing zone safety. (4-11-06)

04. What Is the Deadline for Obtaining Training as Landing Zone Officers? Current EMS ~~*certified*~~ licensed personnel, designated as Landing Zone Officers, must complete the required training described in Subsection 425.03 of these rules by June 30, 2007. ~~*(4-11-06)*~~(7-1-09)T

05. What Is the Deadline for Training as a Landing Zone Officer for EMS ~~*Recertification*~~ License Renewal? All EMS certified personnel will complete training described in Subsection 425.03 of these rules as a component of required continuing education for ~~*recertification*~~ license renewal not later than ~~*June*~~ September 30, 2010. ~~*(4-11-06)*~~(7-1-09)T

06. Who Has the Final Decision to Use an Established Landing Zone? The air medical pilot may refuse the use of an established landing zone. In the event of pilot refusal, the landing zone officer will initiate communications to identify an alternate landing zone. (4-11-06)

426. -- 429. (RESERVED).

430. PATIENT DESTINATION.
The air medical service must have written procedures for determination of patient destination. (4-11-06)

01. Procedures for Destination Protocol and Medical ~~Direction~~ Supervision. The air medical service written procedure will consider the licensed EMS service destination protocol and medical ~~direction~~ supervision received. ~~(4-11-06)~~(7-1-09)T

02. Availability of Written Procedures. The air medical service must make the written procedures available to licensed EMS services that utilize their services. (4-11-06)

03. Determination of Destination Will Honor Patient Preference. The air medical procedures for determination of destination will honor patient preference if the requested facility is capable of providing the necessary medical care and if the requested facility is located within a reasonable distance not compromising patient care or the EMS system. (4-11-06)

(BREAK IN CONTINUITY OF SECTIONS)

500. ~~CERTIFICATION~~ LICENSURE.
In order to practice or represent himself as a ~~First Responder~~ EMR, EMT~~-B~~, AEMT~~-A, EMT-I~~, or ~~EMT-~~Paramedic, an individual must maintain a current ~~certification~~ license issued by the EMS Bureau. ~~(4-6-05)~~(7-1-09)T

501. INITIAL ~~CERTIFICATION~~ LICENSURE.
Upon successful completion of an EMS training program, a candidate may apply for ~~certification~~ licensure to the EMS Bureau. In addition, candidates must satisfy the following requirements: ~~(4-6-05)~~(7-1-09)T

01. Affiliation Required. Candidates for ~~certification~~ licensure at the EMR, EMT~~-B~~, AEMT~~-A, EMT-I~~, and ~~EMT-~~Paramedic levels must have current affiliation with a licensed EMS service which functions at, or higher than, the level of ~~certification~~ licensure being sought by the applicant; ~~(4-6-05)~~(7-1-09)T

02. Required Identification. Candidates for ~~certification~~ licensure at any level must have a state driver's license, an Idaho identification card which is issued by a county driver's license examining station, or identification card issued by the Armed Forces of the United States; and ~~(7-1-97)~~(7-1-09)T

03. Criminal Background Check. A criminal background check must be conducted for all ~~applicants~~ candidates for initial ~~certification~~ licensure in accordance with the standards and procedures established in IDAPA 16.05.06, "Criminal History and Background Checks." The Division or the EMS Bureau may require an updated or additional criminal background check at any time, without expense to the ~~applicant~~ candidate, if there is cause to believe new or additional information will be disclosed. Denial without the grant of an exemption under IDAPA 16.05.06, will result in denial or revocation of ~~certification~~ licensure. ~~(4-6-05)~~(7-1-09)T

04. Fee for Initial ~~Certification~~ Licensure. The fee for initial ~~certification~~ licensure for AEMT~~-A~~, ~~EMT-I,~~ and ~~EMT-~~Paramedic is thirty-five dollars ($35). ~~(4-6-05)~~(7-1-09)T

05. Required Examination. Candidates for ~~*certification*~~ licensure at any level must obtain a passing score on the standardized examination designated by the EMS Bureau. The examination type must correspond to the level of ~~*certification*~~ licensure being sought in accordance with the EMS Standards Manual in effect at the time of application.
~~*(4-6-05)*~~(7-1-09)T

502. -- 509. (RESERVED).

510. ~~*CERTIFICATION*~~ LICENSURE DURATION AND ~~*RECERTIFICATION*~~ LICENSE RENEWAL.
All ~~*certification*~~ licensure is for the following specified intervals of time, during which time required continuing education, refresher courses and other proficiency assurances must be completed in order to renew the ~~*certification*~~ license. ~~*(4-6-05)*~~(7-1-09)T

01. ~~*First*~~ Emergency Medical Responder ~~*Certification*~~ Licensure. An ~~*First*~~ Emergency Medical Responder will be issued ~~*certification*~~ a license for three (3) years. The duration of initial ~~*certification*~~ licensure may be up to forty-two (42) months from the date of examination. Continuing education and refresher course must be conducted ~~*in accordance with*~~ following the EMS Standards Manual in effect at the beginning of the ~~*certification*~~ licensure interval. ~~*(4-6-05)*~~(7-1-09)T

02. EMT~~-B Certification~~ Licensure. An EMT~~-B~~ will be issued ~~*certification*~~ a license for three (3) years. The duration of initial ~~*certification*~~ licensure may be up to forty-two (42) months from the date of examination. Continuing education, refresher course, and proficiency assurance documentation must be conducted in accordance with the EMS Standards Manual in effect at the beginning of the ~~*certification*~~ licensure interval. ~~*(4-6-05)*~~(7-1-09)T

03. AEMT~~-A Certification~~ Licensure. An AEMT~~-A~~ will be issued ~~*certification*~~ a license for two (2) years. The duration of initial ~~*certification*~~ licensure may be up to thirty (30) months from the date of examination. Continuing education, refresher course, and proficiency assurance documentation must be conducted ~~*in accordance with*~~ following the EMS Standards Manual in effect at the beginning of the ~~*certification*~~ licensure interval. The fee for ~~*recertification*~~ license renewal is twenty-five dollars ($25). ~~*(4-6-05)*~~(7-1-09)T

~~***04. EMT-I Certification**. An EMT-I will be issued certification for two (2) years. The duration of initial certification may be up to thirty (30) months from the date of examination. Continuing education, refresher course, and proficiency assurance documentation must be conducted in accordance with the EMS Standards Manual in effect at the beginning of the certification interval. The fee for recertification is twenty-five dollars ($25).* *(4-6-05)*~~

0~~5~~4. ~~*EMT-P Certification*~~ Paramedic Licensure. An ~~*EMT-*~~Paramedic will be issued ~~*certification*~~ a license for two (2) years. The duration of initial ~~*certification*~~ licensure may be up to thirty (30) months from the date of examination. Continuing education, refresher courses, and proficiency assurance documentation will be conducted ~~*in accordance with*~~ following the EMS Standards Manual in effect at the beginning of the ~~*certification*~~ licensure interval. The fee for ~~*recertification*~~ license renewal is twenty-five dollars ($25). ~~*(4-6-05)*~~(7-1-09)T

0~~6~~5. Required Documentation. Documentation of ~~*recertification*~~ license renewal requirements is due to the EMS Bureau prior to the ~~*certification*~~ license expiration date. Failure to submit complete documentation of requirements by the ~~*certification*~~ license expiration date renders the ~~*certification*~~ license invalid and the candidate must not practice or represent himself as ~~*certified*~~ licensed personnel. ~~*(4-6-05)*~~(7-1-09)T

0~~7~~6. Affiliation Required. Candidates for ~~*recertification*~~ license renewal at the EMR, EMT~~-*B*~~, AEMT~~-*A, EMT-I*~~, and ~~*EMT-*~~Paramedic levels must have current affiliation with a licensed EMS service. ~~*(4-6-05)*~~(7-1-09)T

511. LAPSED ~~*CERTIFICATION*~~ LICENSE.
After the expiration date of ~~*certification*~~ a license issued by the EMS Bureau, the ~~*certification*~~ license will no longer be valid unless required ~~*recertification*~~ license renewal documentation has been submitted. No grace periods or extensions to an expiration date may be granted. ~~*(4-6-05)*~~(7-1-09)T

01. Reinstatement of ~~*Certification*~~ License. An individual may submit ~~*recertification*~~ license renewal documentation up to a maximum of two (2) years following the ~~*certification*~~ license expiration date. In order for ~~*certification*~~ license to be reinstated individuals must meet the requirements for initial ~~*certification*~~ license. Continuing education proportionate to the amount of time since the last ~~*recertification*~~ license renewal must be documented. ~~*(7-1-97)*~~(7-1-09)T

02. Re-Entry. An individual whose ~~*certification*~~ license has been expired for more than two (2) years must attend and successfully complete an initial training program for the level of ~~*certification*~~ licensure being sought. All other requirements for initial ~~*certification*~~ licensure must be met. ~~*(4-6-05)*~~(7-1-09)T

512. SURRENDER OF A CERTIFICATION OR LICENSE.
An individual who possesses a current certification or license may relinquish that certification or license at any time by submitting a letter of intent to the EMS Bureau. This action may not prevent investigative or disciplinary action against the individual, which may take place thereafter. ~~*(7-1-97)*~~(7-1-09)T

513. REVERSION.
An individual who possesses a current certification or license may relinquish that certification or license and receive a ~~*certification*~~ license at a lower level with the same expiration date as the original certification or license. The individual must meet all requirements for initial ~~*certification*~~ licensure. This action may not prevent investigative or disciplinary action against the individual which may take place thereafter. ~~*(7-1-97)*~~(7-1-09)T

514. RECIPROCITY.
An individual who has successfully completed an EMS training program approved by another state, U.S. Territory, or branch of the U.S. Armed Services may apply for EMS ~~*certification*~~ licensure if the individual satisfies the criteria for initial ~~*certification*~~ licensure and has current NREMT registration or a state EMS certification or licensure at or above the level of ~~*certification*~~ licensure being sought. ~~*(7-1-97)*~~(7-1-09)T

515. ADMINISTRATIVE LICENSE ACTION.

Any license or certification may be suspended, revoked, denied, or retained only upon compliance with conditions imposed by the Bureau Chief, for any action, conduct, or failure to act which is inconsistent with the professionalism, ~~*and/*~~or standards, or both, established by these rules including, but not limited to the following: ~~*(7-1-97)*~~(7-1-09)T

01. Any Violation. Any violation of these rules. (7-1-97)

02. Failure to Maintain Standards of Knowledge, ~~*and/*~~or Proficiency, or Both. Failure to maintain standards of knowledge, ~~*and/*~~or proficiency, or both, required under these rules; ~~*(7-1-97)*~~(7-1-09)T

03. A Lawful Finding. A lawful finding of mental incompetency. (7-1-97)

04. Performance of Duties. Performance of duties pursuant to said license or certificate while under the influence of alcohol or any illegal substance. (7-1-97)

05. Any Conduct, Action, or Conviction. Any conduct, action, or conviction which does or would result in denial without exemption of a criminal history clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-97)

06. Discipline, Restriction, Suspension or Revocation. Discipline, restriction, suspension or revocation in any other jurisdiction. (7-1-97)

07. Any Conduct, Condition, or Circumstance. Any conduct, condition, or circumstance determined by the Bureau Chief which constitutes a danger or threat to the health, safety, or well-being of persons or property. (7-1-97)

08. Performing Any Medical Procedure or Providing Medication. Performing any medical procedure or providing medication which deviates from or exceeds the scope of practice for the corresponding level of ~~*certification*~~ licensure established under IDAPA ~~*22.01.06*~~ 16.02.02, "~~*Rules for EMS Personnel*~~ Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~*(7-1-97)*~~(7-1-09)T

09. Providing Any Service Without Licensure or Designation. Advertising or providing any service which exceeds the level of licensure and ALS designation; responding to any jurisdiction outside of the coverage area declared on the current EMS service application, with the exception of responses to any locally declared disaster when the response is specifically requested by the incident commander or his designee; or responding in a manner which is in violation of the county EMS ordinance in which the call originates. (4-5-00)

10. Falsification of Applications or Reports. The submission of fraudulent or false information in any report, application, or documentation to the EMS Bureau. (4-5-00)

516. -- 599. (RESERVED).

600. WHO MAY REPORT A DISCIPLINARY VIOLATION.
Any person who knows of a violation of any law or rule by the holder of an emergency medical services certificate or license issued ~~*pursuant to*~~ under these rules may report the violation to the

EMS Bureau. ~~*(7-1-97)*~~(7-1-09)T

601. PRELIMINARY INVESTIGATION.
The EMS Bureau ~~*shall*~~ will make a preliminary investigation of all the facts and circumstances surrounding the reported facts and events and ~~*shall*~~ will make a report of such facts to the ~~*Emergency Medical Services Advisory Committee Disciplinary Subcommittee*~~ Commission for a recommendation of appropriate action. The subject of the investigation shall be given an opportunity to respond in writing, or at the option of the EMS Bureau, in person, to the reported violation. ~~*(7-1-97)*~~(7-1-09)T

602. CONFIDENTIALITY OF INVESTIGATION.
Preliminary investigations and papers in connection with them ~~*shall*~~ will be confidential until a notice of certificate or license action is issued. ~~*(7-1-97)*~~(7-1-09)T

603. NOTICE OF ~~*CERTIFICATE*~~ LICENSURE ACTION.
The Bureau Chief ~~*shall*~~ will notify the certificate or license holder of any intended license action, or ~~*shall*~~ will notify the certificate or license holder that no action will be taken. If the certificate or license holder fails to file an administrative appeal, the intended license action ~~*shall*~~ will become effective without further notice. ~~*(7-1-97)*~~(7-1-09)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1004

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2010**. This temporary rule will cease to be in effect **June 30, 2011, in accordance with H0701 (2010)**.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Bills 656 and 701 passed by the 2010 legislature.

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

Rules changes are being made in these rules to implement the legislative intent in House Bills 656 and 701 passed by the 2010 legislature. Rules changes for this docket include:

Reduction to outpatient hospital costs (H0656); and
Change in definition for hospital floor reimbursement percentage (H0656).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010), Section 13.

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:

Changes related to House Bill 656 (2010) will result in a positive fiscal impact on the state general fund of approximately $18 million per state fiscal year. A related additional positive fiscal impact of $7 million will be realized due to changes in reimbursement mechanisms for certain private hospitals. This will result in an overall cost reduction to the state general fund of $25 million.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Lourie Neal at (208) 287-1162.

DATED this 11th day of August, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1004

400. INPATIENT HOSPITAL SERVICES - DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (3-30-07)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (3-30-07)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (3-30-07)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (3-30-07)

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of

the principal year to assess the percent change between the years. (3-30-07)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third- party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

09. Customary Hospital Charges. Customary hospital charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. (7-1-10)T

a. No more than ninety-one and seven-tenths percent (91.7%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. ~~(3-29-10)~~(7-1-10)T

b. For in-state private hospitals that are not specified in Section 56-1408, Idaho Code, no more than one hundred percent (100%) of covered charges will be reimbursed. (7-1-10)T

c. No more than one hundred one percent (101%) of covered charges will be reimbursed to Critical Access Hospitals (CAH) for in-state private hospitals. (7-1-10)T

d. No more than eighty-seven and one-tenth percent (87.1%) of covered charges will be reimbursed to out-of-state hospitals. (7-1-10)T

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (3-30-07)

11. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (3-30-07)

12. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

13. Excluded Units. Excluded units are distinct units in hospitals which are certified

by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-30-07)

14. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

15. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (3-30-07)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (3-30-07)

16. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (3-30-07)

17. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term "inpatient days" includes Medicaid swing-bed days, administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH threshold computations. (3-30-07)

18. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (3-30-07)

19. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy- making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital).

(3-30-07)

20. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step- down process. (3-30-07)

21. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (3-30-07)

22. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (3-30-07)

a. For inpatient services rendered on or after November 1, 2002, the principal year is the provider's fiscal year ending in calendar year 1998 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement. (3-30-07)

b. For inpatient services rendered on or after January 1, 2007, the principal year is the provider's fiscal year ending in calendar year 2003 and every subsequent fiscal year-end in which a finalized Medicare cost report, or its equivalent, is prepared for Medicaid cost settlement. (3-30-07)

23. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

24. Reasonable Costs. Except as otherwise provided in Section 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (3-30-07)

25. Reimbursement Floor Percentage. ~~*The floor calculation for hospitals with more than forty (40) beds is seventy-seven and four-tenths percent (77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-one and seven-tenths percent (91.7%).*~~ ~~*(3-29-10)*~~(7-1-10)T

a. The floor calculation for out-of-state hospitals is seventy-three and five-tenths percent (73.5%) of Medicaid costs. (7-1-10)T

b. The floor calculation for in-state CAH hospitals is one hundred one percent (101%) of Medicaid costs. (7-1-10)T

c. For in-state hospitals that are not specified in Section 56-1408, Idaho Code, the

floor calculation is eighty-five percent (85%) of Medicaid costs. (7-1-10)T

d. For in-state hospitals that are specified in Section 56-1408, Idaho Code, the floor calculation is seventy-seven and four-tenths percent (77.4%) of Medicaid costs. (7-1-10)T

26. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

27. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is an uninsured patient. (3-30-07)

28. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

415. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (3-30-07)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (3-30-07)

b. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (3-30-07)

c. Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (3-30-07)

d. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or (3-30-07)

ii. The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or (3-30-07)

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or (3-30-07)

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (3-30-07)

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs; or (3-30-07)

ii. The hospital's customary charges; or (3-30-07)

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (3-30-07)

02. Reduction to Outpatient Hospital Costs. ~~*With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospital o*~~Outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: ~~*(3-30-07)*~~(7-1-10)T

a. In-state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare-designated sole community hospital or rural primary care hospital. (7-1-10)T

b. Out-of-state hospitals that are not a Medicare-designated sole community hospital or rural primary care hospital. (7-1-10)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1005

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the December 1, 2010, Idaho Administrative Bulletin, Vol. 10-12

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2011**. This temporary rule will be in effect through **June 30, 2011, i**n accordance with H0701 (2010)**.**

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code; and House Bill 701, passed by the 2010 Legislature.

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

Numerous changes are being made to this chapter of rule that either eliminate or reduce specific benefits or services provided by Medicaid. These changes are being made in order to achieve cost savings under the provisions of H0701 (2010), Sections 13 and 14. These rule changes will be in effect through June 30, 2011. Specific rule changes are as follows:

1. Update the coverage criteria for contact lenses. This will allow the Department of Health and Welfare to limit contact lens benefits to circumstances where vision correction cannot be achieved by eyeglasses. Existing language in this section of rule is outdated and allows for contact lenses when the lens prescription exceeds -4.00 diopters. Due to advances in lens technology most commercial insurers, other state Medicaid programs, and state employee benefits allow provision of contact lenses only for certain conditions not correctable with conventional lenses, or if the prescription is +/- 10.00 diopters. Other minor changes in this section of rule include clarifying requirements for prior authorization for polycarbonate lenses and conditions for payment of contact lens fitting fees;

2. Restructure the reimbursement of primary care case management;

3. Participants benefits for evaluation and diagnostic services are being reduced from an annual combined limitation of 12 hours to 4 hours per calendar year. This combined limitation includes speech and hearing evaluations, physical therapy evaluations, occupational therapy evaluations and diagnostic services. Psychological/Neuropsychological evaluations are separately limited to 4 hours for each eligible participant per calendar year.

4. Reduce mental health treatment plan benefits;

5. Eliminate collateral contact for mental health services, developmental disabilities services, and school-based services.

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

to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010).

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

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

The total estimated fiscal impact from January 1, 2011 to June 30, 2011 is $626,290 ($130,394 in state general funds and $495,896 in federal funds).

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Paul Leary at (208) 364-1836.

DATED this 4th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1005

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

01. AABD. Aid to the Aged, Blind, and Disabled. (3-30-07)

02. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman. (3-30-07)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-30-07)

04. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively

for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (3-30-07)

05. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-30-07)

06. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-30-07)

07. Audit Reports. (3-30-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-30-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-30-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-30-07)

08. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-30-07)

09. Basic Plan. The medical assistance benefits included under this chapter of rules. (3-30-07)

10. Buy-In Coverage. The amount the State pays for Part B of Title XVIII of the Social Security Act on behalf of the participant. (3-30-07)

11. Certified Registered Nurse Anesthetist (CRNA). A Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. (3-30-07)

12. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-30-07)

13. CFR. Code of Federal Regulations. (3-30-07)

14. Clinical Nurse Specialist. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-30-07)

15. CMS. Centers for Medicare and Medicaid Services. (3-30-07)

~~**16. Collateral Contact**. Coordination of care communication that is initiated by a medical or qualified treatment professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. The communication is limited to interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or responsible persons or advising them how to assist participant. Collateral contact is used to:~~ ~~(5-8-09)~~

~~**a.** Coordinate care between professionals who are serving the participant;~~ ~~(5-8-09)~~

~~**b.** Relay medical results and explanations to members of the participant's interdisciplinary team; or~~ ~~(5-8-09)~~

~~**c.** Conduct an intermittent treatment plan review with the participant and his interdisciplinary team.~~ ~~(5-8-09)~~

1~~7~~6. **Co-Payment**. The amount a participant is required to pay to the provider for specified services. (3-30-07)

1~~8~~7. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-30-07)

1~~9~~8. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM. (3-30-07)

~~20~~19. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-30-07)

2~~1~~0. **Director**. The Director of the Idaho Department of Health and Welfare or his designee. (3-30-07)

2~~2~~1. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. (3-30-07)

2~~3~~2. **Durable Medical Equipment (DME)**. Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (5-8-09)

2~~4~~3. **Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-30-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-30-07)

b. Serious impairment to bodily functions. (3-30-07)

c. Serious dysfunction of any bodily organ or part. (3-30-07)

2~~5~~4. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (3-30-07)

2~~6~~5. Facility. Facility refers to a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. (3-30-07)

2~~7~~6. Federally Qualified Health Center (FQHC). An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. (3-30-07)

2~~8~~7. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-30-07)

2~~9~~8. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner that requires ownership transfer to an existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-30-07)

***~~30~~*29. Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (3-30-07)

3~~1~~0. Home Health Services. Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in IDAPA 16.03.07, "Rules for Home Health Agencies." (3-30-07)

3~~2~~1. Hospital. A hospital as defined in Section 39-1301, Idaho Code. (3-30-07)

3~~3~~2. Hospital-Based Facility. A nursing facility that is owned, managed, or operated by, or is otherwise a part of a licensed hospital. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

562. HEALTHY CONNECTIONS: COVERAGE AND LIMITATIONS.

01. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: (3-30-07)

a. Family planning services; (3-30-07)

b. Emergency care (as defined by the Department for the purpose of payment and performed in an emergency department); (3-30-07)

c. Dental care; (4-2-08)

d. Podiatry (performed in the office); (3-30-07)

e. Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)

f. Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)

g. Chiropractic (performed in the office); (3-30-07)

h. Pharmacy (prescription drugs only); (3-30-07)

i. Nursing home; (3-30-07)

j. ICF/ID services; (3-30-07)

k. Immunizations (not requiring an office visit); (4-2-08)

l. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)

m. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)

n. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)

o. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)

p. In-home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)

q. Laboratory services, including pathology; (4-2-08)

r. Anesthesiology services; and (4-2-08)

s. Radiology services. (4-2-08)

t. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed. (1-1-11)T

02. Change in Services That Require a Referral. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and

providers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Case Management Fee. Reimbursement is as follows: (4-2-08)

a. PCPs will be paid a case management fee for primary care case management services based on the level of participants' health care needs and the PCP's availability. ~~*(4-2-08)*~~(1-1-11)T

b. PCPs enrolled in the chronic disease management pay-for-performance program will be paid an enhanced case management fee. (4-2-08)

c. The amount of the fees is determined by the Department and specified in the provider agreement. (4-2-08)

d. The amount of the fee is fixed and the same for all participating PCPs. (4-2-08)

02. Primary Care Case Management. Reimbursement is based on ~~*the number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee.*~~: ~~*(4-2-08)*~~(1-1-11)T

a. The number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package; (1-1-11)T

b. The number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and (1-1-11)T

c. The amount of the case management fee is increased by fifty cents ($.50) per participant when the PCP's office offers extended hours of service equal to or exceeding forty-six (46) hours per week. The amount of extended hours must be verified by and on file with the Department prior to monthly case management fee generation for the increase to be paid. (1-1-11)T

03. Chronic Disease Management. Reimbursement is based on: (4-2-08)

a. The number of participants who have a targeted chronic disease multiplied by the amount of the enhanced case management fee for patient identification; and (4-2-08)

b. The number of instances that the PCP achieved Department specified best practices protocol for the disease being managed multiplied by the amount of the enhanced case

management fee for reported quality indicators. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Enhanced Mental Health Services. Enhanced mental health services are not covered under the Basic Plan with the exception of assessment services. The assessment for determination of need for enhanced mental health services is subject to the requirements for comprehensive assessments at IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 113~~3~~4, and provider qualifications under Section 715 of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131. ~~*(3-30-07)*~~(1-1-11)T

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

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

(BREAK IN CONTINUITY OF SECTIONS)

707. MENTAL HEALTH CLINIC SERVICES: DEFINITIONS.

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

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

~~***03. Functional Assessment**. In rehabilitative mental health, this assessment is used to provide supplemental information to the comprehensive diagnostic assessment and provides*~~

~~*information on the current or required capabilities needed by a participant to maintain himself in his chosen environment. It is a description and evaluation of the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and promote independence. This assessment assists participants to better understand what skills they need to achieve their rehabilitation goals.* (5-8-09)~~

~~***04. Intake Assessment**. An agency's initial assessment of the participant that is conducted by an agency staff person who has been trained to perform mental status examinations and solicit sensitive health information for the purpose of identifying service needs prior to developing an individualized treatment plan. The intake assessment must contain a description of the reason(s) the participant is seeking services and a description of the participant's current symptoms, present life circumstances across all environments, recent events, resources, and barriers to mental health treatment. If this is the initial screening process, then it must be used to document the indicators that mental health services are a medical necessity for the participant.* (5-8-09)~~

03. Comprehensive Diagnostic Assessment Addendum. A supplement to the comprehensive diagnostic assessment that contains updated information relevant to the formulation of a participant's diagnosis and disposition for treatment. (1-1-11)T

0~~5~~4. Interdisciplinary Team. Group that consists of two (2) or more individuals in addition to the participant, the participant's parent or legal guardian, and the participant's natural supports. This may include professionals from several fields or professions. Team members combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan. Professionals working with the participant to fulfill the goals and objectives on the treatment plan are members of the participant's interdisciplinary team whether they attend treatment plan meetings or not. At a minimum, professional members of the team include the medical professional authorizing the treatment plan and the specific agency staff member who is working with the participant. (5-8-09)

0~~6~~5. 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)

0~~7~~6. 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)

0~~8~~7. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. (3-30-07)

0~~9~~8. Neuropsychological Testing. Assessment of brain functioning through structured and systematic behavioral observation. Neuropsychological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory,

language, and executive functions, which are necessary for goal-directed behavior. These data can provide information leading to the diagnosis of a cognitive deficit or to the confirmation of a diagnosis, as well as to the localization of organic abnormalities in the central nervous system; the data can also guide effective treatment methods for the rehabilitation of impaired participants. (5-8-09)

09. New Participant. A participant is considered "new" if he has not received Medicaid-reimbursable mental health clinic or psychosocial rehabilitation services (PSR) in the twelve (12) months prior to the current treatment episode. (1-1-11)T

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

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

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

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

14. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (3-30-07)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

conclusive diagnosis. (5-8-09)

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

708. MENTAL HEALTH CLINIC SERVICES: PARTICIPANT ELIGIBILITY.
Eligibility must be established through the assessment services described under Subsections 709.03.a. and 709.03.b. of these rules. The following are requirements for establishing eligibility for mental health clinic services. (5-8-09)

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

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

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

04. Conditions That Require New ~~*Intake*~~ Assessment and Individualized Treatment Plan. If an individual who is not eligible for Medicaid receives ~~*intake*~~ assessment services from any staff who does not have the qualifications required under Subsection 715.03 of these rules, and later becomes eligible for Medicaid, a new ~~*intake*~~ comprehensive diagnostic assessment and individualized treatment plan are required, which must be developed by a professional listed under Subsection 715.03 of these rules. ~~*(5-8-09)*~~(1-1-11)T

709. MENTAL HEALTH CLINIC SERVICES: COVERAGE AND LIMITATIONS.
All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual. (3-30-07)

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

02. Services or Supplies in Mental Health Clinics That Are Not Reimbursed. Any

service or supplies not included as part of the allowable scope of Medicaid. (5-8-09)

03. Evaluation and Diagnostic Services in Mental Health Clinics. Participants must obtain ~~*either an intake assessment or*~~ a comprehensive diagnostic assessment as the initial evaluation in mental health clinics~~*, depending on their clinical presentation*~~. ~~*(5-8-09)*~~(1-1-11)T

~~***a.*** *An intake assessment is a reimbursable evaluation service when the following conditions are met:* *(5-8-09)*~~

~~*i. The intake assessment must be conducted by staff trained to perform mental status examinations and to conduct interviews intended to solicit sensitive health information for the purpose of identifying a participant's treatment needs and developing an individualized treatment plan.* *(5-8-09)*~~

~~*ii. The intake assessment must be documented in the participant's medical record and must contain a current mental status examination and a review of the participant's strengths and needs.* *(5-8-09)*~~

~~***b***~~**a.** ~~*The comprehensive diagnostic assessment must incorporate information typically gathered in an intake assessment process if an intake assessment has not been completed by the provider agency conducting the comprehensive diagnostic assessment.*~~ The comprehensive diagnostic assessment must include a current mental status examination, a description of the participant's readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan. The assessment must include the five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. A comprehensive diagnostic assessment is a reimbursable service when: ~~*(5-8-09)*~~(1-1-11)T

i. A comprehensive diagnostic assessment is medically necessary in order to provide Basic Plan mental health services ~~*and staff determines that the intake assessment does not provide sufficient clinical information*~~; ~~*(5-8-09)*~~(1-1-11)T

ii. The participant is seeking Enhanced Plan services; ~~*or*~~ and ~~*(5-8-09)*~~(1-1-11)T

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

~~***c.*** *Functional assessment is a reimbursable evaluation service when the comprehensive diagnostic evaluation indicates that the participant may benefit from rehabilitative skill training. A functional assessment must be conducted by a qualified staff person capable of assessing a participant's strengths and needs. The functional assessment must describe and evaluate the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and that promote independence.* *(5-8-09)*~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Emergency services provided to an eligible participant prior to ~~*intake and evaluation is a reimbursable service but*~~ the completion of a comprehensive diagnostic assessment must be fully documented in the participant's medical record; and ~~*(5-8-09)*~~(1-1-11)T

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

~~***07. Collateral Contact**. Collateral contact, as defined in Section 010 of these rules, is a reimbursable service when it is included on the individualized treatment plan and it is necessary for professional staff to share information with members of the participant's interdisciplinary team, or advise them how to assist the participant. (5-8-09)***~~

~~***a.** Collateral contact can be provided face-to-face by agency staff providing treatment services. Face-to-face contact is defined as two (2) or more people meeting in person at the same time: (5-8-09)***~~

~~***b.** Collateral contact can be provided by telephone by agency staff providing treatment services when this is the most expeditious and effective way to provide information. (5-8-09)***~~

0~~*8*~~7. **Pharmacological Management**. Pharmacological management is a reimbursable service when consultations are provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (5-8-09)

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

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

0~~*9*~~8. **Nursing Services**. Nursing services are reimbursable when physician ordered and supervised, and included as part of the participant's individualized treatment plan. (5-8-09)

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

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

~~1~~09. Limits on Mental Health Clinic Services. Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of evaluation, diagnosis and treatment services. A total of ~~*twelve*~~ four (~~*12*~~4) hours per year is the maximum time allowed for a ~~*combination of any evaluative or*~~ diagnostic assessment services ~~*and individualized treatment plan development provided to an eligible participant in a calendar year*~~. 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. ~~*(5-8-09)*~~(1-1-11)T

1~~1~~0. Occupational Therapy Services. Occupational therapy services are reimbursable when included as part of the participant's individualized treatment plan. Agency staff may deliver these services if they are an occupational therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." The practice of occupational therapy encompasses the evaluation, consultation, and treatment of individuals whose abilities to cope with the tasks of daily living are threatened or impaired. It includes a treatment program through the use of specific techniques that enhance functional performance and includes evaluation or assessment of the participant's: (5-8-09)

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

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

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

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

710. MENTAL HEALTH CLINIC SERVICES: WRITTEN INDIVIDUALIZED TREATMENT PLAN.
A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. ~~*Timeframes for treatment plans must not exceed twelve (12) months.*~~ Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules. ~~*(5-8-09)*~~(1-1-11)T

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

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

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

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

a. Statement of the overall goals as identified by the participant or his parent or legal guardian and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized, and must reflect the choices of the participant or his parent or legal guardian. The goals and objectives must address the emotional, behavioral, and skill training needs identified by the participant or his parent or legal guardian through the intake and assessment process. The tasks must be specific to the type of modality used and must specify the frequency and anticipated duration of therapeutic services. (5-8-09)

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

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

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

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

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

c. The treatment plan must be created in direct response to the findings of the ~~*intake and*~~ assessment process. ~~*(5-8-09)*~~(1-1-11)T

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

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

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

03. Treatment Plan Reviews. The agency staff must conduct intermittent treatment plan reviews when medically necessary. The intermittent treatment plan reviews must be conducted with the participant or his legal guardian at least every one hundred twenty (120) days.

During the reviews, the agency staff providing the services, the participant, and any other members of the participant's interdisciplinary team as identified by the participant or his legal guardian must review the progress the participant has made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the participant or his legal guardian and agency staff providing the services. (5-8-09)

04. Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed, ~~*and be completely rewritten*~~ updated, and signed by a physician at least annually. Changes in the types, duration, or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan. ~~*(5-8-09)*~~(1-1-11)T

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

713. ~~*(RESERVED)*~~ MENTAL HEALTH CLINIC SERVICES: RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of mental health clinic services and is responsible for the following tasks: (1-1-11)T

01. Prior Authorization Process. Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The Department will complete the prior authorization process within ten (10) working days from the date all the required information is received from the provider. The specific documentation that is required for prior authorization is dependent on the request for additional services. The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to address the participant's needs in relation to those services. (1-1-11)T

02. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for specific services, a notice of decision citing the reason(s) the participant is ineligible for those services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (1-1-11)T

03. Responding to Requests for Services. When the Department receives from a provider a written request for services that must be prior authorized, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (1-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Assessments. A~~*n intake assessment or*~~ comprehensive diagnostic assessment must be contained in all participant medical records. ~~*(5-8-09)*~~(1-1-11)T

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

03. Documentation. All ~~*intake histories, psychiatric evaluations, psychological*~~ assessments and testing~~*, or specialty*~~ evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. ~~*(3-30-07)*~~(1-1-11)T

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

782. VISION SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies in accordance with the guidelines and limitations listed below. (3-30-07)

01. Eye Examinations. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period for each eligible Medicaid participant to determine the need for glasses to correct a refractive error. Each eligible Medicaid participant, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive eyeglasses within Department guidelines. (3-30-07)

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. (3-30-07)

~~***a.*** *Polycarbonate lenses will be purchased only when there is clear documented evidence that the thickness of the plastic lenses precludes their use (prescriptions above plus or minus two (2) diopters of correction). Documentation must be kept on file by both the examining and supplying providers.* (3-30-07)~~

~~***b***~~**a.** Scratch resistant coating is required for all plastic and polycarbonate lenses. (3-30-07)

~~***c***~~**b.** Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department as defined in the Medical Vendor Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. (3-30-07)

~~***d***~~**c.** All ~~C~~contact lenses require prior authorization by the Department. Contact lenses will be covered only with documentation ~~*that an extreme condition requiring a*~~ of: (1-1-11)T

i. A need for correction equal to or greater than plus or minus ~~*four*~~ ten (~~*-4*~~±10) diopters~~,~~; or (1-1-11)T

ii. An extreme medical condition that does not allow correction through the use of conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other extreme conditions as defined by the Department ~~that preclude the use of conventional lenses. Prior authorization is required by the Department~~. ~~(3-30-07)~~(1-1-11)T

03. Replacement Lenses. Replacement lenses will be purchased prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. (3-30-07)

04. Frames. Frames will be purchased according to the following guidelines: (3-30-07)

a. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for eligible participants; (3-30-07)

b. Except when it is documented by the physician that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (3-30-07)

05. Fitting Fees. Fitting fees for either contact lenses or conventional frames and lenses are covered only when the participant is eligible under the Medicaid program guidelines to receive the supplies associated with the fitting fee. (1-1-11)T

0~~5~~**6. Non-Covered Items**. A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary. Non covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

a. Recommended or Referred by a Physician or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (3-30-07)

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

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

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

03. Reimbursable Services. School districts, charter schools, and the Idaho Infant Toddler program can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter school, or Idaho Infant Toddler Program is seeking reimbursement. (3-30-07)

~~*a. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, or general parent education, or for the Individualized Education Program (IEP) development and review team meetings, even when the parent is present, is not reimbursed. The term collateral contact is defined in Subsection 010.16 of these rules.* (3-29-10)~~

~~*b.*~~**a.** Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (3-30-07)

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

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

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

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

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

~~h~~g. Psychological Evaluation. (3-30-07)

~~i~~h. Psychotherapy. (3-30-07)

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

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

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

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

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

i. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered

by a physician; (3-30-07)

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

854. SCHOOL-BASED SERVICE - PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (3-30-07)

01. Service Detail Reports. A service detail report which includes: (3-30-07)

a. Name of student; (3-30-07)

b. Name and title of the person providing the service; (3-30-07)

c. Date, time, and duration of service; (3-30-07)

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

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

02. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (3-30-07)

03. Documentation of Qualifications of Providers. (3-30-07)

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (3-30-07)

05. Parental Notification. School districts, charter schools, and the Idaho Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule. (3-30-07)

06. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district, charter school, or Idaho Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (3-30-07)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts, charter schools, and the Idaho Infant Toddler program must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration or the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (3-30-07)

b. Notification to Primary Care Physician. School districts, charter schools, and the Idaho Infant Toddler program must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (3-30-07)

i. Results of evaluations within sixty (60) days of completion; (3-30-07)

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (3-30-07)

iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (3-30-07)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district, charter school, or Idaho Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (3-30-07)

d. Parental Consent to Release Information. School districts, charter schools, and the Idaho Infant Toddler program: (3-30-07)

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

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

07. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (3-30-07)

~~***a. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student. (3-30-07)***~~

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

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

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

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

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

~~***g***~~**f.** Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (3-30-07)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

08. Paraprofessionals. The schools and Infant Toddler Program may use paraprofessionals to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as

defined by the appropriate licensure and certification rules. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. (3-29-10)

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

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

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

d. Developmental Therapy. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," for supervision and service requirements. (3-29-10)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0902

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the January 7, 2009, Idaho Administrative Bulletin, Vol. 09-1

EFFECTIVE DATE: The effective date of this temporary rule is **January 1, 2009.**

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(b), 56-203, 56-250 through 257, and 56-1003, Idaho Code.

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

Hearing in Region 2: Monday, January 12, 2009	Hearing in Region 4: Tuesday, January 13, 2009	Hearing in Region 7: Wednesday, January 14, 2009
6:00 p.m. PST State Office Building 1118 F Street 3rd Floor Conference Room Lewiston, ID	6:00 p.m. MST DHW Region IV Office 1720 Westgate Dr., Suite D Room 119 Boise, ID	6:00 p.m. MST State Office Building 150 Shoup Avenue 2nd Floor Conference Room Idaho Falls, ID

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

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

The rule change in this rulemaking is in response to the Governor's Executive Order No. 2008-03, Reduction of General Fund Spending Authority, that directed state agencies to hold back 1% of their general fund budget in the current 2009 fiscal year. In order to comply with this order, Medicaid service benefits were reviewed and the following change is being made to meet the Governor's Order. This change reflects a reduction to the maximum amount of service hours under the Medicaid Enhanced Plan Benefits chapter of rule for Developmental Disability Agencies services.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of this rule is appropriate because of his Executive Order No. 2008-3.

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:

To meet the Governor's Executive Order to hold back 1% of the 2009 fiscal year budget, the following amount includes both state and federal funds to help meet that savings for the 2009 Medicaid budget. The state general fund share of the savings listed is approximately 30%.

Developmental Disabilities (DD) service cap reduction to 22 hours equals $1,082,500 savings.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these changes were required to meet the Governor's Executive Order No. 2008-3.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this temporary and proposed rule, contact Dave Simnitt at (208) 364-1992.

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 January 28, 2009.

DATED this 17th day of November, 2008.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-0902

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

a. All therapy services for children must be identified on the Individual Program Plan

developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. All therapy services for adults with developmental disabilities and ISSH waiver participants must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

02. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies": (3-19-07)

a. Comprehensive Developmental Assessment; (3-19-07)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in this subsection; (3-19-07)

c. Occupational Therapy Assessment; (3-19-07)

d. Physical Therapy Assessment; (3-19-07)

e. Speech and Language Assessment; (3-19-07)

f. Medical/Social History; and (3-19-07)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)

03. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. (3-19-07)

b. Psychotherapy Services. Psychotherapy services, alone or in combination with

supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include: (3-19-07)

i. Individual psychotherapy; (3-19-07)

ii. Group psychotherapy; and (3-19-07)

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (3-19-07)

d. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

e. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

f. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

h. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-19-07)

i. Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (3-19-07)

j. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact

with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (3-19-07)

04. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

a. The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed ~~*thirty*~~ twenty-two (~~*30*~~ 22) hours per week. ~~*(3-19-07)*~~(1-1-09)T

b. Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. (3-19-07)

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (3-19-07)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (3-19-07)

e. Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856. (3-19-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1004

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2010**. This temporary rule will cease to be in effect **June 30, 2011, in accordance with H0701 (2010)**.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Bills 701 and 708, passed by the 2010 legislature.

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

Rule changes are being made in these rules to implement the legislative intent in House Bills 701 and 708 passed by the 2010 legislature. Rule changes for this docket include:

Nursing facility inflation freeze (H0708); and
Intermediate Care Facility for the Mentally Retarded (ICF/MR) inflation rate freeze (H0701).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010), Section 13.

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.

Changes related to House Bill 701 will result in a reduction of $180,000 to the state general fund (cost reduction of $900,000 in total funds (state and federal combined)).

Changes related to House Bill 708 will result in a cost reduction of $500,000 to the state general fund (cost reduction of $2.5 million in total funds (state and federal combined)).

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

DATED this 13th day of August, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1004

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. For the rate period of July 1, 2010, through June 30, 2011, rates will be calculated using cost reports ended in calendar year 2009 with no allowance for inflation to the rate period of July 1, 2010, through June 30, 2011. ~~*(5-8-09)*~~(7-1-10)T

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the

calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free- standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (3-19-07)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (3-19-07)

06. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by fifty percent (50%) not to exceed nine dollars and fifty cents ($9.50) per patient day. There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component. (3-29-10)

07. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

08. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

09. Revenue Offset. Revenues from products or services provided to nonpatients will

be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

258. NURSING FACILITY: COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. For the rate period of July 1, 2010, through June 30, 2011, the direct and indirect cost limits will be fixed at the cost limits established for the rate period July 1, 2009, through June 30, 2010. ~~*(5-8-09)*~~(7-1-10)T

01. Percentage Above Bed-Weighted Median. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (3-19-07)

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital- based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. (3-29-10)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

622. ICF/ID - PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, ~~*an efficiency increment,*~~ exempt costs, and excluded costs. Except as otherwise provided in this section, ~~*ICF/ID providers will be reimbursed in*~~ rates calculated for state fiscal year 201~~*0*~~1 (July 1, 20~~*09*~~10 through June 30, 201~~*0*~~1) ~~*at the same rate of reimbursement that was paid in state fiscal year 2009 (July 1, 2008 through June 30, 2009)*~~ will be calculated by using finalized cost reports ended in calendar year 2008 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2010, through June 30, 2011. ~~*(3-29-10)*~~(7-1-10)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1005

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the November 3, 2010, Idaho Administrative Bulletin, Vol. 10-11

EFFECTIVE DATE: The effective date of the temporary rule is **November 1, 2010.**

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, 56-203, 56-250 through 56-257, Idaho Code; also House Concurrent Resolution No. 48 (2006 Legislature).

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

Tuesday, November 9, 2010 2:00 p.m. MDT	Tuesday, November 9, 2010 6:00 p.m. PDT	Tuesday, November 9, 2010 6:00 p.m. MDT
Medicaid Central Office Conference Rms D, East & West 3232 Elder Street Boise, Idaho	H&W Region I Office Large Conference Room 1120 Ironwood Drive, Suite 102 Coeur d'Alene, Idaho	Human Development Center Room 210 421 Memorial Drive Pocatello, Idaho

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

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

These rules are in response to House Concurrent Resolution No. 48 from the 2006 Legislature, and are focused on continuing Mental Health program revisions that will help clarify program elements and establish supervision and minimum professional requirements. Based on input from stakeholder work groups, provider qualifications are being revised to more accurately define the clinical training expectations for psychosocial rehabilitation program providers.

The following changes are being made to the PSR specialists qualifications:

1. Incorporate newly defined supervision requirements;
2. Include clarification of PSR specialist "continuing" education requirements; and
3. Revise PSR specialist education requirements.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to protect the health and safety of participants receiving PSR services by increasing the educational requirements specific to PSR components needed to qualify PSR specialist workers providing services to individuals with serious and persistent mental illness.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, informal negotiated rulemaking was conducted with stakeholders.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS AND SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule or the temporary rule, contact Patricia Guidry at (208) 364-1813.

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 November 24, 2010.

DATED this 1st day of October, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1005

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 Paragraph 131.03.b. of this rule. ~~*(3-19-07)*~~(11-1-10)T

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 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 ~~*n individual with a Master's degree or a higher credential*~~ licensed master's level professional, as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.03. Certified Psychiatric Rehabilitation Practitioners (CPRP) may provide supervision to PSR Specialist applicants who are working toward their CPRP credential when the certified professional is supervised by a Master's level staff person. ~~*(5-8-09)*~~(11-1-10)T

a. 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)

b. 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)

c. 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. As of June 30, 2009, persons who are working as PSR Specialists delivering Medicaid-reimbursable mental health services may continue to do so until January 1, 2012, at which time they must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the population with whom they work in accordance with the requirements set by the USPRA ~~*be certified as PSR Specialists in accordance with USPRA requirements*~~. An applicant who primarily works as a PSR specialist with transitional age youth between sixteen (16) and eighteen (18) years of age must meet requirements set by USPRA.
~~*(5-8-09)*~~(11-1-10)T

b. ~~*As of July 1, 2009, applicants to become PSR Specialists delivering Medicaid-reimbursable mental health services must have a bachelor's degree from a nationally-accredited university in Primary Education, Special Education, Adult Education, Counseling, Human Services, Early Childhood Development, Family Science, Psychology, or Applied Behavioral Analysis. Applicants who have a major in one (1) of these identified subject areas, but have a bachelor's degree in another field, also meet this requirement.*~~ PSR Specialist applicants hired as of November 1, 2010, must have a bachelor's degree or higher in any field. Each applicant must be educationally prepared in the core competencies of psychiatric rehabilitation principles as defined by USPRA at www.USPRA.org. Applicants must have or successfully complete a minimum of sixty (60) approved classroom hours within the thirty (30) month timeline described at 131.03.c. College coursework and post college education offered through a variety of methods, including continuing education, workshops, and distance-learning count toward this requirement. Classroom hours within the following content areas must be used toward a PSR specialist applicant's continuing education requirements as described in Subsection 130.09 of these rules. All USPRA-approved classroom hours in the required content areas described in these rules must be successfully completed as evidenced by an applicant's documentation of prior education or according to the following timeline:

TABLE 131.03.b - TIMELINE FOR COMPLETION OF USPRA-APPROVED CLASSROOM HOURS	
i. Within ninety (90) days of employment	All applicants must have successfully completed ten (10) classroom hours in Domain I - Interpersonal Competencies: Principles of Psychiatric Rehabilitation and any topic(s) of choice within Domain I. Applicants who 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 an equivalent course. Such training must count toward the ten (10) hour requirement for the first ninety (90) days.
ii. Within one hundred eighty (180) days of employment	All applicants must have successfully completed an additional ten (10) classroom hours, for a cumulative total of twenty (20) hours, in Domain II - Professional Role Competencies: USPRA Guidelines and any topic(s) of choice within Domain II.
iii. Within two hundred and seventy (270) days of employment	All applicants must have successfully completed an additional ten (10) classroom hours, for a cumulative total of thirty (30) hours, in Domain III - Community Integration: Community Support System Principles and any topic(s) of choice from Domain III.

TABLE 131.03.b - TIMELINE FOR COMPLETION OF USPRA-APPROVED CLASSROOM HOURS	
iv. Within three hundred and sixty (360) days of employment	All applicants must have successfully completed an additional ten (10) hours, for a cumulative total of forty (40) hours in Domain IV - Assessment, Planning, and Outcomes: Psychiatric Rehabilitation Readiness and any topic(s) of choice from Domain IV.
v. After one (1) year of employment	All applicants must successfully complete at least eight (8) classroom hours every one hundred eighty (180) days in order to complete the remaining twenty (20) hours of required classroom training, for a cumulative total of sixty (60) hours in Domain V - Interventions for Goal Achievement: Verbal and Non-verbal Communication and at least one (1) choice of topic(s) in each of the following domains, Domain VI - System Competencies and Domain VII - Diversity and Cultural Competency. All applicants must complete the sixty (60) hours of required classroom training within the thirty (30) month time limit.

~~(5-8-09)~~(11-1-10)T

c. ~~*An applicant who meets the educational requirements under Subsection 131.03.b. of this rule*~~ PSR specialist applicants who were hired between July 1, 2009 and October 31, 2010 may work as a PSR Specialist for a period not to exceed ~~*eighteen*~~ thirty (~~*18*~~30) months~~ *while under the supervision of a staff member with a Master's degree or higher credential or a certified PSR Specialist*~~. In order to continue as a PSR Specialist beyond a total period of ~~*eighteen*~~ thirty (~~*18*~~30) months, the worker must ~~*obtain*~~ have completed the USPRA ~~*certification*~~ certificate program or earned a certification in psychiatric rehabilitation based upon the population with whom they work. ~~(5-8-09)~~(11-1-10)T

d. An individual ~~*who has been denied licensure or*~~ 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 with the exception of those individuals who have obtained the USPRA PSR ~~*Specialist certification*~~ credential. ~~(5-8-09)~~(11-1-10)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1006

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the December 1, 2010, Idaho Administrative Bulletin, Vol. 10-12

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2011. This temporary rule will be in effect through June 30, 2011, in accordance with H0701 (2010).**

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code; and House Bill 701, passed by the 2010 Legislature.

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

Numerous changes are being made to this chapter of rule that either eliminate or modify specific benefits or services provided by Medicaid. These changes are being made in order to achieve cost savings under the provisions of H0701 (2010), Sections 13 and 14. These rule changes will be in effect from January 1, 2011 through June 30, 2011.

Specific rules changes are as follows:

1. Eliminate collateral contact benefits;

2. Eliminate supportive counseling benefits;

3. Participant annual assessment benefits are being reduced from a limitation of 12 hours annually, to 4 hours annually. To accommodate this reduction in benefits, provider requirements are being modified. Mental Health (MH) intake and MH functional assessment requirements will be eliminated, and separate limitations for psychological and neuropsychological testing are being established at 4 hours annually. Assessments completed by a DDA are included in the annual assessment limitation being set at 4 hours, and to accommodate this reduction, requirements for agency providers are being modified;

4. Reduce plan development benefits from 12 hours to 6 hours and reduce requirements related to adult developmental disabilities (DD) plan development;

5. Increase DD program efficiency and reduce duplication of required administrative and procedural requirements;

6. Restrict use of certain mental health benefits with certain DD benefits. Participants eligible for skill training must choose to obtain the services from either the MH program or the DD program. Within the MH program, participants are eligible for either partial care (PC) or psychosocial rehabilitation (PSR), to meet their skill training needs;

7. Eliminate service coordination for individuals eligible for personal assistance services (PAS);

8. Reduce MH PSR service benefits;

9. Restrict MH partial care to those individuals who have a diagnosis of serious and persistent mental illness (SPMI);

10. Reduce benefit for MH PSR treatment plan benefits; and

11. Eliminate home health skilled nursing services for A & D waiver participants.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010).

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

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

The total estimated fiscal impact from January 1, 2011 to June 30, 2011 is $7,693,740 ($1,600,298 state general funds and $6,093,442 in federal funds).

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Paul Leary at (208) 364-1836.

DATED this 4th day of November, 2010.

Tamara Prisock
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1006

010. DEFINITIONS A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider’s financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider’s records. (3-19-07)

11. Audit Reports. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)

12. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)

13. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)

15. Case Mix Adjustment Factor. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities

"facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. Certified Family Home. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. Chain Organization. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)

19. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. Clinical Nurse Specialist. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

~~***21. Collateral Contact**. Coordination of care communication that is initiated by a medical or qualified treatment professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. The communication is limited to interpretation or explanation of results of psychiatric or other medical examinations and procedures or other accumulated data to family or responsible persons or advising them how to assist the participant. Collateral contact is used to:* *(5-8-09)*~~

~~***a.** Coordinate care between professionals who are serving the participant; (5-8-09)*~~

~~***b.** Relay medical results and explanations to members of the participant's interdisciplinary team; or (5-8-09)*~~

~~***c.** Conduct an intermittent treatment plan review with the participant and his interdisciplinary team. (5-8-09)*~~

2~~2~~1. Common Ownership. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

2~~3~~2. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)

2~~4~~3. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

2~~5~~4. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes.

(3-19-07)

2~~6~~5. **Cost Component**. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

2~~7~~6. **Cost Reimbursement System**. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)

2~~8~~7. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

2~~9~~8. **Cost Statements**. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

~~30~~29. **Costs Related to Patient Care**. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)

3~~1~~0. **Costs Not Related to Patient Care**. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

3~~2~~1. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

3~~3~~2. **Day Treatment Services**. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

3~~4~~3. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

3~~5~~4. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

3~~6~~5. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

3~~7~~6. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

3~~8~~7. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

3~~9~~8. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and

customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

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. Assessment Hours**. Time allotted for completion of intake, evaluation, and diagnostic services.* (5-8-09)~~

0~~3~~2. 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)

0~~4~~3. 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 participant's diagnosis and disposition for treatment. (1-1-11)T

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. Functional Assessment**. In rehabilitative mental health, this assessment is used to provide supplemental information to the comprehensive diagnostic assessment that provides information on the current or required capabilities needed by a participant to maintain himself in his chosen environment. It is a description and evaluation of the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and promote independence. This assessment assists participants to better understand what skills they need to achieve their rehabilitation goals.* (5-8-09)~~

0~~8~~7. Goal. The desired outcome related to an identified issue. (3-19-07)

0~~9~~8. 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)

~~***10. Intake Assessment**. An agency's initial assessment of the participant that is conducted by an agency staff person who has been trained to perform mental status examinations and solicit sensitive health information for the purpose of identifying service needs prior to developing an individualized treatment plan. The intake assessment must contain a description of the reason(s) the participant is seeking services and a description of the participant's current symptoms, present life circumstances across all environments, recent events, resources, and barriers to mental health treatment. If this is the initial screening process then it must be used to document the indicators that mental health services are a medical necessity for the participant.~~
~~(5-8-09)~~

~~11~~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)

1~~2~~0. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)

1~~3~~1. 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)

1~~4~~2. 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)

1~~5~~3. 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. (1-1-11)T

1~~6~~5. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)

1~~7~~6. 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)

1~~8~~7. Partial Care. Partial care is treatment for ~~*those children with serious emotional disturbance and adults*~~ participants with severe and persistent mental illness (SPMI) whose functioning is sufficiently disrupted so as to interfere 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. ~~*(3-19-07)*~~(1-1-11)T

1~~9~~8. 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)

~~20~~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)

2~~1~~0. 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)

2~~2~~1. 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)

2~~3~~2. 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)

2~~4~~3. 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)

2~~5~~4. 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)

2~~6~~5. 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)

2~~7~~6. 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)

2~~8~~7. 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)

2~~9~~8. **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)

~~30~~29. **Tasks**. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)

3~~1~~0. **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)

3~~2~~1. **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. ~~*For PSR, the participant must also obtain a functional assessment that describes the need for skill training.*~~ Participants who receive skill training can only receive training from one (1) type of service, depending on their eligibility. ~~*(5-8-09)*~~(1-1-11)T

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 ~~*and Partial Care*~~ Services for Children. To be eligible for ~~*partial care services or*~~ 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. A child's level and type of functional impairment must be ~~*described*~~ documented in ~~*the functional assessment*~~ the medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range

in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: ~~*(5-8-09)*~~(1-1-11)T

a. Self-harmful behavior; (4-2-08)

b. Moods/Emotions; or (4-2-08)

c. Thinking. (4-2-08)

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.a. through 112.06.h. of this rule on either a continuous or an intermittent, at least once per year, basis. 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 ~~*described*~~ documented in the ~~*functional assessment*~~ medical record: ~~*(5-8-09)*~~(1-1-11)T

a. Vocational/educational; (4-2-08)

b. Financial; (4-2-08)

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

d. Family; (4-2-08)

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

f. Housing; (4-2-08)

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

h. 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~~*n intake*~~ comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment~~*. A comprehensive diagnostic assessment must be completed in lieu of the intake assessment*~~ if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. ~~*(5-8-09)*~~(1-1-11)T

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. ~~*(5-8-09)*~~(1-1-11)T

113. ~~*ENHANCED OUTPATIENT MENTAL HEALTH SERVICES INTAKE ASSESSMENT*~~ (RESERVED).

~~*Intake assessments may be performed by PSR agencies and Mental Health Clinics for participants who transfer to them from other agencies. Intake assessments must meet requirements listed at IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 709.03. Intake assessments must not be performed as an initial evaluation service in PSR agencies when the PSR agency is performing a comprehensive diagnostic assessment.*~~ ~~*(5-8-09)*~~

(BREAK IN CONTINUITY OF SECTIONS)

115. ~~*ENHANCED OUTPATIENT MENTAL HEALTH SERVICES FUNCTIONAL ASSESSMENT*~~ (RESERVED).

~~*For participants seeking the PSR services of skill training and community reintegration, a functional assessment must be completed by staff who meet the requirements under Section 131 of these rules. Staff performing the CAFAS/PECFAS must be the same staff completing the functional assessment. The functional assessment must incorporate the CAFAS/PECFAS findings. A functional assessment must evaluate the participant's use of critical skills that are needed for adaptive functioning in the various environments in which he lives. The number of skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The functional assessment should include recommendations for training in skill areas from the following list in which the participant is interested in improving his skills.*~~ ~~*(5-8-09)*~~

~~***01. Health or Medical Issues**. Focus must be on participant's skills for self-managing health and medical issues including ability to schedule and keep medical appointments, maximize opportunities for communicating health status to medical providers, and adherence to medical regimens prescribed by healthcare providers.* *(5-8-09)*~~

~~***02. Vocational And Educational Status**. Focus must be on skill development to maximize adaptive occupational functioning as applicable to work or school settings.* *(5-8-09)*~~

~~***03. Financial Status**. Focus must be on the participant's skills for managing personal finances.* *(5-8-09)*~~

~~***04. Social Relationships and Supports**. Focus must be on participant's skills for establishing and maintaining personal support systems or relationships and participant's skills for developing and participating in leisure, recreational, or social interests.* *(5-8-09)*~~

~~***05. Family Status**. Focus must be on participant's skills needed to carry out family roles and participate in family relationships.* *(5-8-09)*~~

~~***06. Basic Living Skills**. Focus must be on participant's skills needed to perform age-appropriate basic living skills, including transition to adulthood.* *(5-8-09)*~~

~~***07. Housing**. Focus must be on participant's skills for obtaining and maintaining safe and appropriate housing.* *(5-8-09)*~~

~~***08. Community and Legal Status**. Focus must be on participant's skills necessary for community living including compliance with rules, laws, and informal agreements made with others.* *(5-8-09)*~~

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 ~~T~~treatment plan~~ning~~ 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. ~~*(5-8-09)*~~(1-1-11)T

01. Goals. Services identified on the treatment plan must support the goals ~~*of any of the following*~~ that are applicable to the participant's identified needs. For adults, the treatment plan must incorporate the need for psychiatric services identified by the comprehensive diagnostic assessment. For children, the treatment plan must incorporate the substantial impairment areas identified by the CAFAS. Participant's goals may include any of the following: ~~*(5-8-09)*~~(1-1-11)T

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 ~~*new*~~ updated treatment plan must be developed for participants who will continue in treatment beyond twelve (12) months. ~~*(5-8-09)*~~(1-1-11)T

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)

(BREAK IN CONTINUITY OF SECTIONS)

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES -- DESCRIPTIONS.

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

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

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

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

ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and ~~*the functional assessment and*~~ be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and outcomes; and ~~*(5-8-09)*~~(1-1-11)T

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 can not receive skill training in psychosocial rehabilitation, developmental therapy, intensive behavioral intervention, or residential habilitation services. ~~*(3-19-07)*~~(1-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Assessment. Assessment services must not exceed ~~*six*~~ four (~~6~~4) hours per participant annually. The following assessments are included in this limitation: ~~*(5-8-09)*~~(1-1-11)T

~~***a.*** *Intake Assessment;* *(5-8-09)*~~

~~***b***~~**a.** Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually;

~~(5-8-09)~~(1-1-11)T

~~**c.** *Functional Assessment.* (5-8-09)~~

~~**d.** *Psychological and Neuropsychological Assessments. 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)~~

~~**e**~~**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. (1-1-11)T

0~~2~~3. **Individualized Treatment Plan**. Two (2) hours ~~*per year per participant per provider agency are available for treatment plan development*~~ 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. ~~(3-19-07)~~(1-1-11)T

0~~3~~4. **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)

0~~4~~5. **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)

0~~5~~6. **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. ~~*Up to five (5) additional weekly hours are available with prior authorization.*~~ Participants who receive skill training in psychosocial rehabilitation can not receive skill training in partial care, developmental therapy, intensive behavioral intervention, or residential habilitation services. ~~(5-8-09)~~(1-1-11)T

0~~6~~7. **Pharmacological Management**. Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)

~~**07. Collateral Contact**. *Collateral contact services beyond six (6) hours 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 140.0~~9~~7 of these rules. ~~(3-19-07)~~(1-1-11)T

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

~~**a.** *Hours and Type of Service.* The Department must authorize the number of hours and type of services, as specifically required in these rules, which could be reasonably expected to *lead to achievement of the individualized treatment plan objectives*~~ address the participant's needs in relation to those services. ~~(5-8-09)~~(1-1-11)T

~~**b.** *Authorization Time Period. Prior authorizations are limited to no more than a twelve (12) month period and must be reviewed and updated to continue.* (5-8-09)~~

03. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for ~~*PSR agency*~~ specific services, a notice of decision citing the reason(s) the participant is ineligible for ~~*PSR agency*~~ 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. ~~(5-8-09)~~(1-1-11)T

04. ~~*Increases in Individualized Treatment Plan Hours or Change in Service Type*~~ Responding to Requests for Services. When the Department is notified, in writing, by the provider of ~~*recommended increases in hours or change in type of*~~ service~~s~~ ~~*provided*~~ that require~~s~~

prior authorization, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. ~~*A clear rationale for the increase in hours or change in service type must be included with the request.*~~ ~~*(5-8-09)*~~(1-1-11)T

~~***05. Changes to Individualized Treatment Plan Objectives or Tasks.*** *When a provider believes that an individualized treatment plan needs to be revised without increasing hours or changing type of service, the provider should amend the individualized treatment plan at the time of the next treatment plan review or when substantial changes in the participant's mental status or circumstances require immediate changes in the plan objectives. The amended individualized treatment plan must be retained in the participant's record and submitted to the Department upon request.*~~ ~~*(5-8-09)*~~

0~~6~~5. **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 Provision. Each provider must have signed additional terms to the general provider agreement with the Department. (3-19-07)

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

04. 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.
~~*(5-8-09)*~~(1-1-11)T

05. 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. ~~*(5-8-09)*~~(1-1-11)T

06. 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)

07. 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)

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

(BREAK IN CONTINUITY OF SECTIONS)

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. ~~*(5-8-09)*~~(1-1-11)T

a. A copy of the review must be sent to the Department upon request. Failure to do so may ~~*result in the loss of a prior authorization or*~~ result in a recoupment of reimbursement provided for services delivered after the intermittent staffing review date. ~~*(5-8-09)*~~(1-1-11)T

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)

(BREAK IN CONTINUITY OF SECTIONS)

306. PERSONAL ASSISTANCE AGENCY (PAA) - QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. (5-8-09)

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-19-07)

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-19-07)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-19-07)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-19-07)

d. Provision of a licensed professional nurse (RN) or, where applicable, a QIDP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-19-07)

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)

g. Billing Medicaid for services approved and authorized by the RMS; (3-19-07)

h. Collecting any participant contribution due; (5-8-09)

i. Conducting, at least annually, participant satisfaction or quality control reviews which are available to the Department and the general public; and (5-8-09)

~~***j.*** *Making referrals for PCS-eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified.* *(3-19-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

b. Assistance with activities of daily living; (3-19-07)

c. Meals, including special diets; (3-19-07)

d. Housekeeping; (3-19-07)

e. Laundry; (3-19-07)

f. Transportation; (3-19-07)

g. Opportunities for socialization; (3-19-07)

h. Recreation; and (3-19-07)

i. Assistance with personal finances. (3-19-07)

j. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the

participant's home, community, work, school or recreational settings. (3-30-07)

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-19-07)

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

a. Intermittent Assistance may include the following. (3-19-07)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in their home. (3-19-07)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)

a. Rent or own their own home; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no regular caretaker for extended periods of time; and (3-19-07)

d. Are unable to prepare a balanced meal. (3-19-07)

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-19-07)

11. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caretaker for extended periods of time; and (3-19-07)

d. Would otherwise require extensive routine supervision. (3-19-07)

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

~~***15. Service Coordination**. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (3-19-07)~~

~~***a.** All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (3-19-07)~~

~~***b.** The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (3-19-07)~~

16~~5~~. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are ~~not~~ appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: ~~(3-19-07)~~(1-1-11)T

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

1~~7~~6. Habilitation. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate

behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (4-2-08)

1~~8~~7. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-30-07)

b. Federal Financial Participation (FFP) can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-30-07)

1~~9~~8. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

329. AGED OR DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

~~***j.*** *To make referrals for service coordination for a PCS-eligible participant when a need for such services is identified; and* *(5-8-09)*~~

~~***k***~~**j.** To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care

staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," including: (4-2-08)

i. Companion services; (4-2-08)

ii. Chore services; and (4-2-08)

iii. Respite care services. (4-2-08)

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-2-08)

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

~~***07. Service Coordination**. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules. (3-19-07)~~

0~~8~~7. **Consultation Services**. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in

hiring, firing, training, and supervising their own care providers. (3-19-07)

0~~9~~8. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-2-08)

~~1~~09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

1~~1~~0. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (3-19-07)

1~~2~~1. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks History and Background Checks." (4-2-08)

1~~3~~2. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's

need. (3-19-07)

143. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

154. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

165. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

176. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

187. Residential Habilitation Provider Qualifications. Residential habilitation services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a residential habilitation agency. The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-30-07)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable diseases; (3-30-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a program coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (3-30-07)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

e. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-30-07)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

g. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-30-07)

1~~9~~8. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

~~20~~19. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

2~~1~~0. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under

the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

508. BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. (3-19-07)

01. Adult. A person who is eighteen (18) years of age or older. (3-29-10)

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. Clinical Review. A process of professional review that validates the need for continued services. (3-19-07)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

07. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

08. Level of Support. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)

09. Person-Centered Planning Process. A meeting facilitated by the plan developer,

comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-19-07)

10. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

~~***13. Plan Monitor Summary**. A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns.* (3-19-07)~~

1~~4~~3. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

1~~5~~4. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

1~~6~~5. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

1~~7~~6. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

1~~8~~7. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

1~~9~~8. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

~~20~~19. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

2~~1~~0. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

2~~2~~1. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

2~~3~~2. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

2~~4~~3. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

2~~5~~4. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

512. BEHAVIOR HEALTH PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and

developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of DDA services and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. ~~(3-19-07)~~(1-1-11)T

a. A medical, social and developmental history for adult participants is completed by the Department or its contractor. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (1-1-11)T

b. A medical social and developmental history for children is required when the child is accessing DDA services for the first time, and must reflect accurate information about the participants' status. (1-1-11)T

c. After the initial medical social development history for children, additional Medical Social and Development History services for children will be reimbursed if a qualified professional determines that it no longer reflects the current status of the participant. Please refer to IDAPA 16.04.11, "Developmental Disabilities Agencies (DDA)," Subsections 602.01 and 602.02. (1-1-11)T

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-19-07)

a. The SIB-R for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. (1-1-11)T

b. The SIB-R for children is required for all children accessing DDA services for the first time. (1-1-11)T

c. After the initial SIB-R assessment for children, additional SIB-R assessments will be reimbursed if a qualified professional determines that the assessment no longer reflects the current status of the participant. Please refer to IDAPA 16.04.11.602.01, and 16.04.11.602.02. (1-1-11)T

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07)

513. BEHAVIOR HEALTH PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service,

the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-19-07)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services provided outside of a Development Disabilities Agency (DDA). (4-2-08)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (3-19-07)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews ~~*and complete a plan monitor summary after the six (6) month review and for annual plan development*~~. ~~*(3-19-07)*~~(1-1-11)T

e. Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-19-07)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

~~***07. Plan Monitor Summary**. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review.* *(3-19-07)***~~

0~~*8*~~7. **Content of the Plan of Service**. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

0~~*9*~~8. **Negotiation for the Plan of Service**. If the services requested on the plan of service fall outside the individualized budget or do not reflect the assessed needs of the participant, the plan developer and the participant will have the opportunity to negotiate the plan of service with the Department's care manager. Services will not be paid for unless they are authorized on the plan of service. (3-29-10)

~~*1*~~09. **Informed Consent**. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

1~~*1*~~0. **Provider Implementation Plan**. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

12~~2~~1. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on ~~*changes in a participant's need or demonstrated outcomes*~~ a change to a cost, a change in services, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~*(3-19-07)*~~(1-1-11)T

13~~2~~2. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is

provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

143. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-19-07)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted ~~*with the annual plan, services will not be authorized*~~ to the plan monitor, services will not be written into the individual service plan and therefore will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules.
~~*(3-19-07)*~~(1-1-11)T

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

154. ~~Reconsiderations,~~ Complaints, and Administrative Appeals.
~~(3-19-07)~~(1-1-11)T

~~**a.** Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request.~~ ~~(3-19-07)~~

~~b~~a. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid, Bureau of Care Management. (3-19-07)

~~c~~b. Administrative Appeals. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."
~~(3-19-07)~~(1-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

653. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

a. All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. All therapy services for adults with developmental disabilities must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-29-10)

02. Assessment and Diagnostic Services. ~~Twelve~~ Four (~~12~~4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year, excluding psychological assessments which are separately limited to 4 hours annually. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies":
~~(3-19-07)~~(1-1-11)T

a. Comprehensive Developmental Assessment. In order to avoid duplication of

services, prior to conducting a Comprehensive Developmental Assessment, the DDA must demonstrate that they have formally requested any existing comprehensive developmental assessment completed by either by the Department, a medical provider, a Developmental Disability Agency, a school district, charter school or The Idaho Infant Toddler Program. Comprehensive developmental assessments are not required unless one does not exist, or upon updating the current assessment, the qualified professional appropriately documents that there has been a change in the participant's represented status and assessed need. Please refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," Subsections 602.01 and 602.02; ~~(3-19-07)~~(1-1-11)T

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the ~~twelve~~ four (~~12~~4) hour limitation described in this subsection; ~~(3-19-07)~~(1-1-11)T

c. Occupational Therapy Assessment; (3-19-07)

d. Physical Therapy Assessment; (3-19-07)

e. Speech and Language Assessment; (3-19-07)

f. Medical/Social History. In order to avoid duplication of services, prior to completing a medical/social history, the DDA must demonstrate that they have formally requested any existing medical social history completed by either by the Department, a medical provider, a Developmental Disability Agency, a school district, charter school, or The Idaho Infant Toddler Program. A medical/social history is required if one does not exist, or if the existing document does not accurately reflect the participant's current status. Please refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," Subsections 602.01 and 602.02; and ~~(3-19-07)~~(1-1-11)T

g. ~~*Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview.*~~ Psychiatric Diagnostic Interview. In order to avoid duplication of services, prior to completing a psychiatric diagnostic interview, the DDA must demonstrate that they have formally requested any existing psychiatric diagnostic interview completed by either by the Department, medical provider, a Developmental Disability Agency, a school district, charter school or The Idaho Infant Toddler Program. A psychiatric diagnostic interview is required if the qualified agency professional indicates that one is necessary to accurately reflect the participant's status and assessed need. Please refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," Subsections 602.01 and 602.02; ~~(3-19-07)~~(1-1-11)T

03. Psychological Assessment. Psychological assessments will be limited to four (4) hours annually per participant. Psychological assessment is not included in the DDA annual assessment limitation of four (4) hours. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," Section 601 for General Requirements for Psychological Assessments and IDAPA 16.04.11, "Developmental Disabilities Agencies," Section 602 for Requirements for Current Assessments. (1-1-11)T

0~~3~~4. **Therapy Services**. Developmental disabilities agency services must be

recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. ~~(3-19-07)~~(1-1-11)T

b. Psychotherapy Services. Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include: (3-19-07)

i. Individual psychotherapy; (3-19-07)

ii. Group psychotherapy; and (3-19-07)

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

~~***c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one-to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year.***~~
~~***(3-19-07)***~~

~~***d***~~**c.** Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

~~***e***~~**d.** Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

~~***f***~~**e.** Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

~~***g***~~**f.** Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

iii. Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. (1-1-11)T

~~h~~g. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-19-07)

~~***i.*** *Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable.* *(3-19-07)*~~

***j*h.** Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (3-19-07)

0~~4~~5. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

0~~5~~6. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

a. The combination of therapy services listed in Subsections 653.0~~3~~4.a. through 653.0~~3~~4.~~g~~f. of these rules must not exceed twenty-two (22) hours per week. ~~*(1-1-09)T*~~(1-1-11)T

b. Therapy services listed in Subsections 653.0~~3~~4.a. through 653.0~~3~~4.~~g~~f. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. ~~*(3-19-07)*~~(1-1-11)T

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (3-19-07)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the

participant is being transported to and from the agency. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

703. DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

d. Residential Habilitation services will not be reimbursed if a participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. (1-1-11)T

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in

a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote

adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

13. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

724. ~~*SERVICE COORDINATION -- ELIGIBILITY: INDIVIDUALS ELIGIBLE FOR PERSONAL ASSISTANCE SERVICES*~~ (RESERVED).

~~*An individual is eligible to receive service coordination if he meets the following requirements in Subsections 724.01 and 724.02 of this rule.* (5-8-09)~~

~~***01. Personal Care and Waiver Services**. Adults age eighteen (18) and older, who is eligible to receive state plan personal care services, or Aged and Disabled Home and Community Based Waiver Services.* (5-8-09)~~

~~***02. Need Assistance**. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community.* (5-8-09)~~

(BREAK IN CONTINUITY OF SECTIONS)

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)

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)

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

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.*** *Crisis Assistance for Individuals Eligible for Personal Assistance Services. Crisis hours are not available until eight (8) hours of service coordination have already been provided in the month. Crisis hours must be authorized by the Department.* *(5-8-09)*~~

~~***e***~~**d.** 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)

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 Personal Assistance Services. Up to eight (8) hours per*~~

~~*month for participants who are eligible to receive personal assistance services.* *(5-8-09)*~~

~~*e*~~**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)

~~*d*~~**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)

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 ~~*personal assistance*~~ participants diagnosed with developmental disabilities. ~~*Plan development for adult participants with developmental disabilities cannot exceed twelve (12) hours annually.* *(5-8-09)*~~(1-1-11)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1007

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the December 1, 2010, Idaho Administrative Bulletin, Vol. 10-12

EFFECTIVE DATE: The effective date of these temporary rules is **November 1, 2010.**

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(b), 56-203(7), 56-203(9), 56-250 through 56-257, Idaho Code; also House Bill 701 passed by the 2010 legislature.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 15, 2010.

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

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

The Department of Health and Welfare is implementing a selective contract system for the Medicaid Enhanced Plan Benefits dental services based on legislative intent to control costs, improve access, and maintain quality. These rules provide the needed changes to implement the "Idaho Smiles" insurance plan through Blue Cross of Idaho for eligible enhanced plan participants.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of these rules are appropriate in order to comply with deadlines in amendments to governing law or federal programs and confers a benefit.

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

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

This is a cost containment effort, first initiated in 2007 with outsourcing Basic Plan dental benefits. The resulting selective contract with Blue Cross and DentaQuest was so successful under this managed care arrangement that the Enhanced Plan participants are

being added under this single contract. This results in improved access and no additional costs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are being made to implement the legislative intent in H0701 passed by the 2010 Legislature.

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 Arla Farmer at (208) 364-1958.

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 December 22, 2010.

DATED this 5th day of November, 2010.

Tamara Prisock
DHW - Administrative Procedures Section
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P.O. Box 83720
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1007

080. DENTAL SERVICES - DEFINITIONS.

01. Dental Services. Dental services under this chapter of rules are provided for ~~*the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion*~~ preventive, diagnostic, restorative, periodontic, prosthetic, oral surgery, and adjunctive dental treatment. These services must be ~~*purchased from*~~ provided by a licensed dentist or denturist.
~~*(5-8-09)*~~(11-1-10)T

02. Idaho Smiles. Idaho Smiles is a dental insurance plan which is provided through a selective contract with Blue Cross of Idaho for basic dental services defined in Subsection 080.01 of this rule. (11-1-10)T

081. DENTAL SERVICES - PARTICIPANT ELIGIBILITY.

01. ~~***Children's Coverage***~~. ~~*Dental services for children, covered through the month of their twenty-first birthday, are listed in Sections 080 through 085 of these rules.*~~ **Participants From Birth to Age Sixty-Five**. Dental services for participants from birth through the month of the participant's sixty-fifth birthday who are eligible for Medicaid's Basic and Enhanced Plans, including women on the Pregnant Women (PW) program, are covered under the Idaho Smiles dental insurance plan, which is the result of a selective contract with Blue Cross of Idaho.
~~*(5-8-09)*~~(11-1-10)T

02. ~~***Adult Coverage***~~. ~~*Covered dental services for Medicaid eligible persons who are past the month of their twenty-first birthday who are not eligible under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Pregnant Women (PW), Qualified Medicare Beneficiary (QMB), or under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," are listed in Subsections 082.14 and 082.15 of these rules.*~~ **Participants Over Age Sixty-Five**. Covered dental services for Medicaid eligible adults who are past the month of the participant's sixty-fifth birthday and qualify for, but have not chosen to enroll in the Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," are covered for dental services through Medicaid's fee-for-service dental program. The benefits for this group of participants are listed in Subsections 082.03 through 082.10 of these rules. ~~*(5-8-09)*~~(11-1-10)T

~~***03. Limitations on Orthodontics***. *Orthodontics are limited to participants from birth to twenty-one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in the Appendix A of these rules. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant.* *(5-8-09)*~~

~~***04. Participants Eligible for Other Programs***. *Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services.* *(5-8-09)*~~

082. DENTAL SERVICES - COVERAGE AND LIMITATIONS.

01. Covered Dental Services. Dental services for eligible participants described in Section 081 of these rules are covered by Medicaid's ~~*as described in Section 081 of these rules*~~ fee-for-service dental program described in Subsections 082.03 through 082.10 of this rule. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association. All dental services must be documented in the participant's record to include: procedure, surface, and tooth number, if applicable. This record must be maintained for a period of six (6) years.
~~*(5-8-09)*~~(11-1-10)T

02. Non-Covered Services. Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules. (5-8-09)

03. Diagnostic Dental Procedures.

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
a. General Oral Evaluations. The following evaluations are not allowed in combination of the same day:	
D0120	Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.
D0150	Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.
~~*D0160*~~	~~*Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.*~~
~~*D0170*~~	~~*Re-evaluation, limited, problem focused. Established participant, not post-operative visit.*~~
b. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three (3) year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
~~*D0240*~~	~~*Intraoral occlusal film.*~~
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six (36) month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four (4) bitewings or periapicals are allowed in addition to a panoramic film.
~~*D0340*~~	~~*Cephalometric film. Allowed once in a twelve (12) month period.*~~
~~***c. Test And Laboratory Examination.***~~	
~~*D0460*~~	~~*Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.*~~
~~*D0470*~~	~~*Diagnostic casts.*~~
~~***d. Diagnostic.***~~	

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
~~*D0999*~~	~~*Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.*~~

~~*(5-8-09)*~~(11-1-10)T

04. Dental Preventive Procedures. ~~*Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.*~~

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
a. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
~~*D1120*~~	~~*Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.*~~
b. Fluoride Treatments.	
~~*D1203*~~	~~*Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants under age twenty (21).*~~
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
~~***c. Other Preventive Services***.~~	
~~*D1351*~~	~~*Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.*~~
~~***d. Space Management Therapy***.~~ ~~*Space maintainers are allowed to hold space for missing teeth for participants under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.*~~	
~~*D1510*~~	~~*Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.*~~
~~*D1515*~~	~~*Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.*~~
~~*D1520*~~	~~*Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.*~~
~~*D1525*~~	~~*Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.*~~
~~*D1550*~~	~~*Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.*~~

~~*(5-8-09)*~~(11-1-10)T

05. Dental Restorati~~ons~~ve Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis. ~~(5-8-09)~~(11-1-10)T

~~**a.** *Posterior Restoration.* (5-8-09)~~

~~*i. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial).* (5-8-09)~~

~~*ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications.* (5-8-09)~~

~~*iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications.* (5-8-09)~~

~~*iv. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications.* (5-8-09)~~

~~**b.** *Anterior Proximal Restoration.* (5-8-09)~~

~~*i. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle.* (5-8-09)~~

~~*ii. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.* (5-8-09))~~

~~*iii. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.* (5-8-09)~~

~~*iv. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved.* (5-8-09)~~

~~**c.** *Amalgams and Resin Restoration.* (5-8-09)~~

~~*i. Reimbursement for pit restoration is allowed as a one (1) surface restoration.* (5-8-09)~~

~~*ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration.* (5-8-09)~~

~~*iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately.* (5-8-09)~~

~~**d.** *Crowns.* (5-8-09)~~

~~*i. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required.* (5-8-09)~~

~~ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification.~~ ~~(5-8-09)~~

TABLE 082.05 - DENTAL RESTORATI~~ONS~~VE PROCEDURES	
Dental Code	**Description**
~~e~~a. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent. ~~Tooth designation required.~~
D2150	Amalgam - two (2) surfaces, primary or permanent. ~~Tooth designation required.~~
D2160	Amalgam - three (3) surfaces, primary or permanent. ~~Tooth designation required.~~
D2161	Amalgam - four (4) or more surfaces, primary or permanent. ~~Tooth designation required.~~
~~f~~b. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	Resin - one (1) surface, anterior. ~~Tooth designation required.~~
D2331	Resin - two (2) surfaces, anterior. ~~Tooth designation required.~~
D2332	Resin - three (3) surfaces, anterior. ~~Tooth designation required.~~
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. ~~Tooth designation required.~~
D2390	Resin based composite crown, anterior, primary or permanent. ~~Tooth designation required.~~
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
~~g. Crowns.~~	
~~D2710~~	~~Crown resin indirect. Tooth designation required. Prior authorization required.~~
~~D2721~~	~~Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.~~
~~D2750~~	~~Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.~~
~~D2751~~	~~Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.~~
~~D2752~~	~~Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.~~
~~D2790~~	~~Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.~~
~~D2791~~	~~Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.~~
~~D2792~~	~~Crown, full cast noble metal. Tooth designation required. Prior authorization required.~~
~~h~~c. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.

TABLE 082.05 - DENTAL RESTORATIONSIVE PROCEDURES	
Dental Code	**Description**
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

(5-8-09)(11-1-10)T

06. Endodontics. Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
c. Root Canal Therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
~~*D3347*~~	~~*Retreatment of previous root canal therapy, bicuspid. Tooth designation required.*~~
~~*D3348*~~	~~*Retreatment of previous root canal therapy, molar. Tooth designation required.*~~
~~***d. Apicoectomy/Periradicular Services.***~~	
~~*D3410*~~	~~*Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.*~~
~~*D3421*~~	~~*Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.*~~
~~*D3425*~~	~~*Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.*~~
~~*D3426*~~	~~*Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.*~~
~~*D3430*~~	~~*Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.*~~
~~*D3999*~~	~~*Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.*~~

~~*(5-8-09)*~~(11-1-10)T

07. Periodontics.

TABLE 082.07 - PERIODONTICS	
Dental Code	**Description**
~~***a. Surgical Services.***~~	
~~*D4210*~~	~~*Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.*~~
~~*D4211*~~	~~*Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.*~~
~~***b***~~a. **Non-Surgical Periodontal Services**.	
~~*D4320*~~	~~*Provisional splinting - intracoronal.*~~
~~*D4321*~~	~~*Provisional splinting - extracoronal.*~~
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.

TABLE 082.07 - PERIODONTICS	
Dental Code	**Description**
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
~~c~~b. **Other Periodontal Services**.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the participant's plaque control efficiency.
~~D4999~~	~~Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.~~

~~(5-8-09)~~(11-1-10)T

08. Prosthodontics. The prosthodontic procedures in this section are covered for dentists and denturists unless designated otherwise. Denturists are reimbursed at 85% of the dental fee schedule. Medicaid allows complete or immediate denture construction for each arch once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. ~~(5-8-09)~~(11-1-10)T

~~**a.** *Removable Prosthodontics.* (5-8-09)~~

~~*i. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions.* (5-8-09)~~

~~*ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed.* (5-8-09)~~

~~*iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the participant is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed.* (5-8-09)~~

~~**b.** *Removable Prosthodontics by Codes.*~~

TABLE 082.08~~*.b.*~~ - PROSTHODONTICS	
Dental Code	**Description**
~~*i*~~**a.** Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
~~*ii*~~**b.** Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth. This procedure is only covered for dentists.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth. This procedure is only covered for dentists.
~~*D5213*~~	~~*Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.*~~
~~*D5214*~~	~~*Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.*~~
~~*iii*~~**c.** Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
~~*iv*~~**d.** Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
~~*v*~~**e.** Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
~~*D5670*~~	~~*Replace all teeth and acrylic on cast metal framework (maxillary).*~~
~~*D5671*~~	~~*Replace all teeth and acrylic on cast metal framework (mandibular).*~~

TABLE 082.08~~.b.~~ - PROSTHODONTICS	
Dental Code	**Description**
~~vi~~f. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
~~vii~~g. Other Removable Prosthetic Services.	
~~D5850~~	~~Tissue conditioning, maxillary - per denture unit.~~
~~D5851~~	~~Tissue conditioning, mandibular per denture unit.~~
~~D5899~~	~~Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.~~
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

~~(5-8-09)~~(11-1-10)T

~~09. Maxillo-Facial Prosthetics.~~

~~TABLE 082.09 - MAXILLO FACIAL PROSTHETICS~~	
~~Dental Code~~	~~Description~~
~~D5931~~	~~Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5932~~	~~Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5933~~	~~Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5934~~	~~Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5935~~	~~Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5936~~	~~Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.~~

~~TABLE 082.09 - MAXILLO FACIAL PROSTHETICS~~	
~~D5951~~	~~Feeding aid. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5952~~	~~Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5953~~	~~Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5954~~	~~Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5955~~	~~Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5958~~	~~Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5959~~	~~Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5960~~	~~Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5982~~	~~Surgical stent. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5988~~	~~Surgical splint. Narrative required when prior authorizing. Requires prior authorization.~~
~~D5999~~	~~Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.~~

~~(5-8-09)~~

~~10. Fixed Prosthodontics.~~

~~TABLE 082.10 - FIXED PROSTHODONTICS~~	
~~Dental Code~~	~~Description~~
~~Other Fixed Prosthetic Services.~~	
~~D6930~~	~~Re-cement fixed partial denture.~~
~~D6980~~	~~Fixed partial denture repair.~~
~~D6999~~	~~Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.~~

~~(5-8-09)~~

~~11~~09. Oral Surgery.

TABLE 082.~~11~~09 - ORAL SURGERY	
Dental Code	Description
a. Simple Extraction.	

TABLE 082.~~11~~09 - ORAL SURGERY	
Dental Code	**Description**
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
c. Other Surgical Procedures.	
~~*D7270*~~	~~*Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.*~~
~~*D7280*~~	~~*Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to participants under twenty-one (21) years of age.*~~
~~*D7281*~~	~~*Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants under twenty-one (21) years of age.*~~
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
~~*d. Alveoloplasty.*~~	
~~*D7320*~~	~~*Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.*~~
~~*e. Excision of Bone Tissue.*~~	
~~*D7471*~~	~~*Removal of lateral exostosis. Maxilla or mandible. Arch designation required.*~~
~~*f*~~d. **Surgical Incision**.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
~~*g*~~e. **Repair of Traumatic Wounds**.	
D7910	Suture of recent small wounds up to five (5) cm.

TABLE 082.~~11~~09 - ORAL SURGERY	
Dental Code	**Description**
~~h~~f. **Other Repair Procedures**.	
~~D7960~~	~~Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.~~
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
~~D7999~~	~~Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.~~

~~(5-8-09)~~(11-1-10)T

~~12. Orthodontics.~~

~~TABLE 082.12 - ORTHODONTICS~~	
~~Dental Code~~	~~Description~~
~~a. Limited Orthodontics.~~ ~~Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.~~	
~~D8010~~	~~Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.~~
~~D8020~~	~~Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.~~
~~D8030~~	~~Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.~~
~~D8040~~	~~Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.~~
~~b. Comprehensive Orthodontic Treatment.~~ ~~The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.~~	
~~D8070~~	~~Comprehensive orthodontic treatment of transition dentition. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.~~
~~D8080~~	~~Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.~~
~~D8090~~	~~Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.~~

~~TABLE 082.12 - ORTHODONTICS~~	
~~Dental Code~~	~~Description~~
~~c. Minor Treatment to Control Harmful Habits.~~	
~~D8210~~	~~Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.~~
~~D8220~~	~~Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.~~
~~d. Other Services.~~	
~~D8670~~	~~Adjustments monthly. When utilizing treatment codes D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.~~
~~D8680~~	~~Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.~~
~~D8691~~	~~Repair of orthodontic appliance. Limited to one (1) occurrence.~~
~~D8999~~	~~Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.~~

~~(5-8-09)~~

1~~3~~0. Adjunctive General Services.

TABLE 082.1~~3~~0 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). ~~Open and drain is included in the fee for root canal when performed during the same sitting.~~ Tooth or quadrant designation required. No other services covered same day.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.

TABLE 082.1~~3~~0 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
c. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
d. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.
~~*D9430*~~	~~*Office visit for observation (during regularly scheduled hours). No other services performed.*~~
D9440	Office visit after regularly scheduled hours.
e. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
~~*D9940*~~	~~*Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.*~~
~~*D9951*~~	~~*Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per visit basis. Allowed once every twelve (12) months.*~~
~~*D9952*~~	~~*Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.*~~

TABLE 082.1~~3~~0 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

~~(5-8-09)~~(11-1-10)T

~~14.~~ ~~Dental Codes For Adult Services~~. *~~The following dental codes are covered for adults after the month of their twenty-first birthday.~~*

~~TABLE 082.14 - DENTAL CODES FOR ADULTS~~	
~~**Dental Code**~~	~~**Description**~~
~~**a. Dental Diagnostic Procedures.**~~ ~~*The definitions for these codes are in Subsection 082.03 of theses rules.*~~	
~~*i. General Oral Evaluations.*~~	
~~*D0120*~~	~~*Periodic oral evaluation.*~~
~~*D0140*~~	~~*Limited oral evaluation.*~~
~~*D0150*~~	~~*Comprehensive oral evaluation.*~~
~~*ii. Radiographs/Diagnostic Images.*~~	
~~*D0210*~~	~~*Intraoral - complete series.*~~
~~*D0220*~~	~~*Intraoral periapical - first film.*~~
~~*D0230*~~	~~*Intraoral periapical - each additional film.*~~
~~*D0270*~~	~~*Bitewing - single film.*~~
~~*D0272*~~	~~*Bitewings - two (2) films.*~~
~~*D0274*~~	~~*Bitewings - four (4) films.*~~
~~*D0277*~~	~~*Vertical bitewings - seven (7) to eight (8) films.*~~
~~*D0330*~~	~~*Panoramic film.*~~
~~**b. Dental Preventive Procedures.**~~ ~~*The definitions for these codes are in Subsection 082.04 of theses rules.*~~	
~~*i. Dental Prophylaxis.*~~	
~~*D1110*~~	~~*Prophylaxis - adult.*~~
~~*ii. Fluoride Treatments.*~~	
~~*D1204*~~	~~*Topical application of fluoride - prophylaxis not included - adult.*~~
~~**c. Dental Restorative Procedures.**~~ ~~*The definitions for these codes are in Subsection 082.05 of theses rules.*~~	
~~*i. Amalgam Restorations.*~~	
~~*D2140*~~	~~*Amalgam - one (1) surface, primary or permanent.*~~
~~*D2150*~~	~~*Amalgam - two (2) surfaces, primary or permanent.*~~

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
ii. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
iii. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
d. Endodontics. The definitions for these codes are in Subsection 082.06 of theses rules.	
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
e. Periodontics. The definitions for these codes are in Subsection 082.07 of theses rules.	
i. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
ii. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.
f. Prosthodontics. The definitions for these codes are in Subsection 082.08.b. of theses rules.	
i. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D5140	Immediate denture - mandibular.
ii. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
iii. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
v. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Oral Surgery. The definitions for these codes are in Subsection 082.11 of theses rules.	
i. Extractions.	

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
ii. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.
D7230	Removal of impacted tooth - partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
iii. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
iv. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. Adjunctive General Services. The definitions for these codes are in Subsection 082.13 of theses rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(5-8-09)

15. Denturist Procedure Codes. (5-8-09)

a. The following codes are valid denturist procedure codes:

TABLE 082.15.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)

TABLE 082.15.a. DENTURIST PROCEDURE CODES	
Dental Code	Description
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(5-8-09)

b. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (5-8-09)

083. DENTAL SERVICES - PROCEDURAL REQUIREMENTS.

01. Dental Prior Authorization. Authorization is not required for dental procedures, except under Dental Code D5899, when unable to deliver full denture, described in Section 082 of these rules. All This procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered to reimbursement. Prior aAuthorization requires a written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment narrative stating why the provider was unable to deliver the dentures or why the patient refused them. (5-8-09)(11-1-10)T

02. Denturist Prior Authorization. Prior authorization is not required for the dentist procedures except for dental code D5899 found in Subsection 082.15.a. of these rules. (5-8-09)

03. Crowns. (5-8-09)

a. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (5-8-09)

b. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (5-8-09)

084. DENTAL SERVICES PROVIDER QUALIFICATIONS AND DUTIES (RESERVED).

All dental services must be documented in the participant's record to include: procedure, surface, and tooth number, if applicable. This record must be maintained for a period of six (6) years. (5-8-09)

085. DENTAL SERVICES - PROVIDER REIMBURSEMENT.

Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and

customary charges are paid up to the Medicaid maximum allowance. Denturists are reimbursed at eighty-five percent (85%) of the dentists' reimbursement. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. ~~(5-8-09)~~(11-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

~~APPENDIX A~~

~~IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX~~

~~OVERBITE:~~	~~MEASUREMENT/POINTS:~~	~~SCORE:~~
~~Lower incisors: striking lingual of uppers at incisal~~	~~1/3 = 0~~	
~~Striking lingual of uppers at middle~~	~~1/3 = 1~~	
~~Striking lingual of uppers at gingival~~	~~1/3 = 2~~	
~~**OPENBITE:** (millimeters) *a,b~~		
~~Less than……~~	~~2 mm = 0~~	
	~~2-4 mm = 1~~	
	~~4+ mm = 2~~	
~~**OVERJET:** (millimeters) *a~~		
~~Upper……~~	~~2-4 mm = 0~~	
~~Measure horizontally parallel to occlusal plane.~~	~~5-9 mm = 1~~	
	~~9+ mm = 2~~	
~~Lower……~~	~~0-1 mm = 0~~	
	~~2 mm = 1~~	
	~~3+ mm = 2~~	
~~**POSTERIOR X-BITE:** (teeth) *b~~		
~~Number of teeth in x-bite:~~	~~0-2 = 0~~	
	~~3 = 1~~	
	~~4 = 2~~	
~~**TOOTH DISPLACEMENT:** (teeth) *c, d, e~~		

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	
		TOTAL SCORE: _____

Scoring Definitions:

Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

a) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.
b) Missing teeth count as 1, if the space is still present.
c) Do not score teeth that are not fully erupted.
d) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1101

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the January 5, 2011, Idaho Administrative Bulletin, Vol. 11-1

EFFECTIVE DATE: The effective dates of the temporary rule are **September 1, 2010**, and **January 1, 2011**.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(7), 56-203(9), 56-250 through 56-257, Idaho Code; also House Bill 701 passed by the 2010 legislature.

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

These rules are being amended to reflect reimbursement methodologies that have been recently approved by the Centers for Medicare and Medicaid through the Medical Assistance State Plan amendment process for mental health clinics, developmental disability agencies, and rehabilitative mental health services. The reimbursement methodologies for these providers in the current rules are no longer accurate.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010), Section 13.

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.

While the methodology is different than the historical approach, it is designed to be budget neutral. This rulemaking has no anticipated fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 24th day of November, 2010.

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THE FOLLOWING IS THE TEXT OF DOCKET 16-0310-1101

119. ~~*(RESERVED)*~~ 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: (9-1-10)T

a. The mental health clinic's actual charge; or (9-1-10)T

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. (9-1-10)T

02. Reimbursement. (9-1-10)T

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. (9-1-10)T

b. For other health professionals authorized to administer mental health services, the statewide reimbursement rate for mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 119.03 of this rule. Reimbursement rates for partial care, and social history and evaluation are set at a percentage of the statewide target reimbursement rate. (9-1-10)T

03. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (9-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

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. (9-1-10)T

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. (9-1-10)T

b. For other health professionals authorized to administer rehabilitative mental health services, the statewide target reimbursement rate for rehabilitative mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 140.09 of this rule. Reimbursement rates for intake assessment, functional assessment, individual and group skill

training, and community reintegration are set at a percentage of the statewide target reimbursement rate. (9-1-10)T

c. 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. (9-1-10)T

09. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (9-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

656. DDA SERVICES: PROVIDER REIMBURSEMENT.

~~*Payment for agency services must be in accordance with rates established by the Department.* (3-19-07)~~

01. Reimbursement. (9-1-10)T

a. For physician services where mid-levels are authorized to administer developmental disability services, the Department reimburses based on the Department's Medical Assistance fee schedule. (9-1-10)T

b. For other health professional authorized to administer developmental disability services, the statewide reimbursement rate for developmental disability services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program- related costs, and general and administrative costs based on a cost survey as described in Subsection 656.02 of this rule. (9-1-10)T

02. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (9-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

706. DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department.

(3-19-07)

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-19-07)

04. Reimbursement. For select services, the statewide reimbursement rate for DD waiver services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 706.05 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. (9-1-10)T

05. Cost Survey. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (9-1-10)T

(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 728.07 of these rules. (5-8-09)

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 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
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~~, *unless he receives personal care services or aged and disabled waiver services*~~. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. ~~*(5-8-09)*~~(1-1-11)T

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

09. Reimbursement. The statewide reimbursement rate for a service coordinator and a paraprofessional was derived by using: (9-1-10)T

a. Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment-related expenditures; (9-1-10)T

b. Non-productive time including vacation, sick time, and holiday; and (9-1-10)T

c. An indirect general and administrative cost based on a survey as described in Subsection 736.10 of this rule. (9-1-10)T

10. Survey. The Department will conduct a time study, general and administrative cost, and mileage cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain time and cost data to provide services. (9-1-10)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1102

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the January 5, 2011, Idaho Administrative Bulletin, Vol. 11-1

EFFECTIVE DATE: The effective date of the temporary rule are **October 1, 2010**. **This temporary rule will cease to be in effect June 30, 2011, in accordance with H0701 (2010).**

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(7), 56-203(9), 56-250 through 56-257, Idaho Code; also House Bill 701 passed by the 2010 legislature.

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

This rulemaking changes Nursing Facilities Services by adding new subsections of rule that describe the nursing facility assessment and the nursing facility adjustment payment. These changes allow additional assessments on skilled nursing facilities to maintain adequate state trustee and benefit funds to the extent that a general fund shortfall exists or as limited by the maximum assessment of 5.5%. An additional purpose is to draw down additional federal matching funds by maximizing reimbursement for allowable costs available through the state Medicaid plan.

These rule changes will cease to be in effect on June 30, 2011.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs. Temporary rulemaking is also being done under the authority granted in House Bill 701 (2010), Section 13.

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.

The fee changes described under the descriptive summary above are being implemented under the authority granted in House Bill 701 (2010), Section 13.

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

The nursing facility amendments will reduce the state general funds by approximately $10,000,000 per state fiscal year. This cost reduction has already been incorporated into the Division of Medicaid's 2011 appropriation.

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

DATED this 24th day of November, 2010.

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THE FOLLOWING IS THE TEXT OF DOCKET 16-0310-1102

235. NURSING FACILITY: PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of long term care is to ~~*in*~~exclude the date of the participant's discharge ~~*only if the discharge occurred after 3 p.m. and is not discharged to a related ICF/ID provider*~~. If a Medicaid patient dies in a nursing home, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. ~~*(3-19-07)*~~(10-1-10)T

03. Nursing Facility Assessment. The Department will collect from all nursing facilities, except those owned by the state, a nursing facility assessment thirty (30) days from the date of invoice. The aggregated amount for assessments for all nursing facilities, during a fiscal year, will be an amount not exceeding five and a half percent (5.5%) of the total aggregate net patient service revenue of assessed facilities from each provider's prior fiscal year. (10-1-10)T

04. Nursing Facility Adjustment Payments. All nursing facilities will be eligible for annual nursing facility adjustment payments. Adjustment payments will be made within the state fiscal year 2011 to reimburse covered Medicaid expenditures in the aggregate within the upper payment limit. (10-1-10)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.11 - DEVELOPMENTAL DISABILITIES AGENCIES

DOCKET NO. 16-0411-1101

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the January 5, 2011, Idaho Administrative Bulletin, Vol. 11-1

EFFECTIVE DATE: The effective date of the temporary rule is **January 1, 2011**.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized by Section 39-4605, Idaho Code.

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

The Department is making several changes in this docket which will help meet the Department's appropriations budget for State Fiscal Year 2011. These temporary rules will be in place from January 1, 2011 through June 30, 2011. The changes include clarification of assessment requirements for individuals receiving developmental disability services, and the removal of supportive counseling and collateral contact services. These changes will not affect the quality of care or access to services.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is necessary for compliance with deadlines in amendments to governing law. These changes are needed to meet budget reductions for State Fiscal Year 2011.

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

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

The changes in this docket are regulatory changes related to budget reductions in other benefit rule dockets that carry the fiscal impact statements.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Paige Grooms at (208) 947-3364.

DATED this 12th day of November, 2010.

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THE FOLLOWING IS THE TEXT OF DOCKET 16-0411-1101

010. DEFINITIONS -- A THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (7-1-06)

01. Adult. A person who is eighteen (18) years of age or older. (3-29-10)

02. Agency. A developmental disabilities agency (DDA) as defined in Section 010 of this rule. (7-1-06)

03. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-06)

04. Baseline. A baseline is pre-intervention or annual data used to gauge a participant's level of independent performance as a basis for initiating therapeutic intervention. (7-1-06)

05. Board. The Idaho State Board of Health and Welfare. (7-1-06)

06. Communicable Disease. A disease that may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. (7-1-06)

07. Comprehensive Assessment. An assessment used for diagnostic and evaluation purposes that contains uniform criteria used to contribute to the determination of a person's eligibility for DDA services and the need for those services. (7-1-06)

08. Deficiency. A determination of non-compliance with a specific rule or part of rule. (7-1-06)

09. Department. The Idaho Department of Health and Welfare. (7-1-06)

10. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (7-1-06)

a. A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-06)

b. Certified by the Department to provide DDA services to people with developmental disabilities, in accordance with these rules; (7-1-06)

c. A business entity, open for business to the general public; and (7-1-06)

d. Primarily organized and operated to provide developmental therapy and other DDA services and the corresponding assessments to people with developmental disabilities.

(7-1-06)

11. DDA Services. A DDA provides services that are rehabilitative and habilitative in nature. DDA services include assessment, diagnostic, and treatment services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. Each DDA is required to provide developmental therapy, and, in addition, also must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. A DDA may also opt to provide pharmacological management, psychiatric diagnostic interviews, community crisis supports, ~~*collateral contact,*~~ and Intensive Behavioral Intervention (IBI). ~~*(7-1-06)*~~(1-1-11)T

12. Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (7-1-06)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (7-1-06)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-06)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (7-1-06)

13. Developmental Specialist. A person qualified to conduct developmental assessments and developmental therapy under these rules. (7-1-06)

14. Developmental Therapy. Developmental therapy is the use of therapeutic intervention and positive behavioral techniques that result in measurable skill acquisition or prevent regression where documentation shows that regression is anticipated in the following areas: (7-1-06)

a. Self-care; (7-1-06)

b. Receptive and expressive language; (7-1-06)

c. Learning; (7-1-06)

d. Mobility; (7-1-06)

e. Self-direction; (7-1-06)

f. Capacity for independent living; and (7-1-06)

g. Economic self-sufficiency. (7-1-06)

15. Habilitation. The process of developing skills and abilities. (7-1-06)

16. Individualized Family Service Plan (IFSP). An initial or annual plan of service, developed by the Department or its designee, for providing early intervention services to children birth to age three (3). This plan must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C. (7-1-06)

17. Individual Program Plan (IPP). An initial or annual plan of service developed by the DDA for providing DDA services to: (7-1-06)

a. Children from three (3) through seventeen (17) years of age; (7-1-06)

b. Participants up to age twenty-one (21) who are receiving IBI or additional DDA services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; or (7-1-06)

c. Participants eighteen (18) years of age or older receiving DDA services and who are using the Home and Community Based Services (HCBS) Waiver for the Aged and Disabled (A&D), State Plan PCS, or are living in a nursing facility. (7-1-06)

18. Individual Service Plan (ISP). An initial or annual plan of service for persons eighteen (18) years of age or older that identifies all services and supports developed under a person-centered planning process. The Department authorizes each ISP at least once every three hundred sixty-five (365) days. This type of plan is referred to as the "plan of service" in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. (3-29-10)

19. Integration. The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-06)

20. Intensive Behavioral Intervention (IBI). Individualized, comprehensive interventions that have been shown to be effective and are used on a short term, one-to-one basis that: (7-1-06)

a. Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills; or (7-1-06)

b. Broaden an otherwise severely restricted range of interest; and (7-1-06)

c. Increase the child's ability to participate in other therapies and environments. (7-1-06)

21. Medical/Social History. An assessment completed by a licensed social worker or

other qualified professional working within the scope of his license. This assessment of the participant's history, home, family, and physical environment is part of the process used to determine his treatment needs. (7-1-06)

22. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving DDA services under an ISP. The information is used in the assessment and authorization of a participant's services. (7-1-06)

23. Objective. A behavioral outcome statement developed to address a particular need identified for a participant. An objective is written in measurable terms that specify a target date for completion, no longer than one (1) year in duration, and include criteria for successful attainment of the objective. (7-1-06)

011. DEFINITIONS -- P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (7-1-06)

01. Paraprofessional. A person, such as an aide or therapy technician, who is qualified to assist a qualified professional in providing services to persons with developmental disabilities. (7-1-06)

02. Participant. A person who has been identified as having a developmental disability as defined in this chapter, and who is receiving services through a DDA. (7-1-06)

03. Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (7-1-06)

04. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (7-1-06)

05. Plan Developer. A paid or nonpaid person identified by the participant who is responsible for developing an ISP and subsequent addenda that covers all services and supports, based on a person-centered planning process. (7-1-06)

06. Plan Monitor. A person who oversees the provision of services on the ISP on a paid or non-paid basis. The plan developer is the plan monitor unless there is a Service Coordinator, in which case the Service Coordinator assumes both roles. (7-1-06)

07. Plan of Service. An initial or annual plan that identifies services and supports. Plans are developed annually. In this chapter of rules, "plan of service" may refer to any of the following: IFSP, IPP, or ISP. (7-1-06)

08. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. (7-1-06)

09. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. (7-1-06)

10. Probe. A probe is data gathered on an intermittent basis, after a baseline is established, to measure a participant's level of independent performance as related to an identified objective. (7-1-06)

11. Program Implementation Plan. A plan that details how DDA goals from the plan of service will be accomplished. (7-1-06)

12. Provider. An agency, or an individual working for an agency, that furnishes DDA services under the provisions of these rules. (7-1-06)

13. Provider Status Review. The written documentation that identifies a participant's progress toward goals defined in the ISP. (7-1-06)

14. Provisional Certificate. A certificate issued by the Department to a DDA with deficiencies that do not adversely affect the health or safety of participants. A provisional certificate is issued contingent upon the correction of deficiencies in accordance with an agreed-upon plan. A provisional certificate is issued for a specific period of time, up to, and not exceeding, six (6) months. (7-1-06)

15. Psychotherapy. Treatment methods using a specialized, formal interaction between a qualified professional and an individual, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, or intrapersonal, interpersonal, and psychosocial dynamics, or the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. (7-1-06)

16. Qualified Professional. A professional delivering services within the scope of his practice and in accordance with the requirements of this chapter. (7-1-06)

17. Rehabilitation. The process of improving skills or level of adjustment to increase the person's ability to maintain satisfactory independent or dependent functioning. (7-1-06)

18. Repeat Deficiency. A violation or deficiency found on a resurvey or revisit to a DDA that was also found during the previous survey or visit. (7-1-06)

19. Service. Assessment, diagnosis, therapy, training, assistance, or support provided to a person with a developmental disability by a DDA. (7-1-06)

20. Service Coordination. Service coordination is an activity that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. The delivery of service coordination is governed by IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 720 through 779. (7-1-06)

21. Service Coordinator. An individual who provides service coordination to a

Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 720 through 779. (7-1-06)

22. Specific Skill Assessment. A type of assessment used to determine the baseline or the need for further intervention for the discipline area being assessed. (7-1-06)

23. Staff. Employees or contractors of an agency who provide services, including those persons with whom the agency has a formal, written agreement. (7-1-06)

24. Supervision. Initial direction and procedural guidance by a qualified professional and periodic inspection of the actual work performed at the service delivery site. (7-1-06)

~~***25. Supportive Counseling**. A method used by qualified professionals to assist individuals with developmental disabilities to learn how to solve problems and make decisions about personal, social, relationship, and other interpersonal concerns. Supportive counseling does not seek to reach unconscious material.* *(3-30-07)*~~

2~~6~~5. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (7-1-06)

26. Updated Assessments. Assessments are considered updated and current when a qualified professional with the same credentials or same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participants file that the assessment continues to reflect the participants current status and assessed needs. (1-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

405. STANDARDS FOR PARAPROFESSIONALS PROVIDING DEVELOPMENTAL THERAPY AND IBI.
When a paraprofessional provides either developmental therapy or IBI, the agency must assure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under Section 415 of these rules and must meet the qualifications under Section 420 of these rules. A paraprofessional providing IBI must be supervised by an IBI professional; a paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. Paraprofessionals providing developmental therapy to children birth to three (3) must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. For paraprofessionals to provide developmental therapy or IBI in a DDA, the agency must adhere to the following standards: (7-1-06)

01. Limits to Paraprofessional Activities. The agency must assure that paraprofessionals do not conduct participant assessments, establish a plan of service, develop a

Program Implementation Plan, or conduct ~~*collateral contact or*~~ IBI consultation. These activities must be conducted by a professional qualified to provide the service. ~~*(7-1-06)*~~(1-1-11)T

02. Frequency of Supervision. The agency must assure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or more often if necessary: (7-1-06)

a. Give instructions; (7-1-06)

b. Review progress; and (7-1-06)

c. Provide training on the program(s) and procedures to be followed. (7-1-06)

03. Professional Observation. The agency must assure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to assure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-06)

04. Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

601. GENERAL REQUIREMENTS FOR ASSESSMENT RECORDS.

01. Completion of Assessments. Assessments must be completed or obtained prior to the delivery of therapy in each type of service. (7-1-06)

02. Update of Assessments. Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. (7-1-06)

03. Psychological Assessment. A ~~*current*~~ psychological assessment must be ~~*completed*~~ updated or obtained: ~~*(7-1-06)*~~(1-1-11)T

~~***a.*** *When the participant is receiving a behavior modifying drug(s);* *(7-1-06)*~~

~~***b***~~**a.** Prior to the initiation of restrictive interventions to modify inappropriate behavior(s); (7-1-06)

~~***c.*** *Prior to the initiation of supportive counseling;* *(3-30-07)*~~

~~***d***~~**b.** When it is necessary to determine eligibility for services or establish a diagnosis;

(7-1-06)

~~e~~**c.** When a participant has been diagnosed with mental illness; or (7-1-06)

~~f~~**d.** When a child has been identified to have a severe emotional disturbance. (7-1-06)

602. REQUIREMENTS FOR CURRENT ASSESSMENTS.
Assessments must accurately reflect the current status of the participant. (7-1-06)

01. Current Assessments for Ongoing Services. To be considered current, assessments must be completed or updated at least ~~annually~~ every two (2) years for service areas in which the participant is receiving services on an ongoing basis. ~~(7-1-06)~~ (1-1-11)T

02. Updated Assessments. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the participant's current status in that service area. If, during the required review of the assessment(s), the latest assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so. (7-1-06)

03. Medical/Social Histories and Medical Assessments. Medical/social histories and medical assessments must be completed at a frequency determined by the recommendation of a professional qualified to conduct those assessments. (7-1-06)

04. Intelligence Quotient (IQ) Tests. Once initial eligibility has been established, annual assessment of IQ is not required for persons whose categorical eligibility for DDA services is based on a diagnosis of being intellectually disabled. IQ testing must be reconducted on a frequency determined and documented by the agency psychologist or at the request of the Department. (7-1-06)

(BREAK IN CONTINUITY OF SECTIONS)

720. OPTIONAL SERVICES.
DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, ~~collateral contact,~~ and Intensive Behavioral Intervention (IBI)~~, and supportive counseling~~. All services must be provided by qualified individuals in accordance with the requirements in Section 420 of these rules.
~~(3-30-07)~~(1-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

724. ~~COLLATERAL CONTACT~~ (RESERVED).

~~*Collateral contact is consultation with or treatment direction given to a person with a primary relationship to a participant for the purpose of assisting the participant to live in the community. Collateral contact must:* (7-1-06)~~

~~***01. Conducted by Agency Professionals**. Be conducted by agency professionals qualified to deliver services and be necessary to gather and exchange information with individuals having a primary relationship to the participant.* (7-1-06)~~

~~***02. Face to Face or by Telephone**. Be conducted either face-to-face or by telephone when telephone contact is the most expeditious and effective way to exchange information. Collateral contact does not include general staff training, general staffings, regularly scheduled parent-teacher conferences, general parent education, or treatment team meetings, even when the parent is present.* (7-1-06)~~

~~***03. On the Plan of Service**. Have a goal and objective stated on the plan of service that identifies the purpose and outcome of the service and is conducted only with individuals specifically identified on the plan of service. Program Implementation Plans are not required for collateral contact objectives.* (7-1-06)~~

(BREAK IN CONTINUITY OF SECTIONS)

~~***726. SUPPORTIVE COUNSELING.***~~

~~***01. Psychological Assessment**. The initial and ongoing need for the service of supportive counseling must be recommended in a current psychological assessment.* (3-30-07)~~

~~***02. On Plan of Service**. Supportive counseling must be provided in accordance with the requirements for the plan of service. The type, amount, frequency and duration of this service must be specified on the plan of service.* (3-30-07)~~

~~***03. Staff Qualifications**. Supportive counseling must be provided by a professional listed under Subsection 712.02 of these rules or by a licensed social worker (LSW).* (3-30-07)~~

72~~7~~6. -- 799. (RESERVED).

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1002

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

This docket published in the December 1, 2010, Idaho Administrative Bulletin, Vol. 10-12

EFFECTIVE DATE: The effective date of the temporary rule is **November 5, 2010.**

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 54-1404(11), Idaho Code.

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

Board rules currently require that applicants for certification as a medication assistant pass an examination as a measure of beginning competence. Because of the anticipated very low volume of applicants, it is not financially feasible for vendors to develop an affordable psychometrically sound, legally defensible examination for use in Idaho, which has prevented the Board from issuing certification to otherwise qualified applicants.

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

This rulemaking confers a benefit to applicants and the general public by removing the examination requirement for certification of a medication assistant and allows the Board to issue certification upon determination of competency of the applicant through processes other than by administration of an examination. The rulemaking also authorizes the issuance of a temporary license pending successful completion and receipt of the competency evaluation, when other certification requirements have been satisfied.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Sandra Evans, M.A.Ed., R.N., Executive Director, at (208) 334-3110 Ext. 26.

DATED this 8th day of November, 2010.

Sandra Evans, M.A.Ed., R.N.
Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
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THE FOLLOWING IS THE TEXT FOR DOCKET NO. 23-0101-1002

494. APPLICATION FOR CERTIFICATION FOR MEDICATION ASSISTANT - CERTIFIED.

01. Application Submission. An applicant for medication assistant - certified shall submit to the Board: (3-26-08)

a. A completed, notarized application form provided by the Board; (3-26-08)

b. A notarized affidavit of graduation from an approved medication assistant - certified education and training program; (3-26-08)

c. Evidence of successful completion of a medication assistant - certified competency evaluation, approved by the Board; (3-26-08)

d. Payment of application fees as established in Section 497 of these rules; and (3-26-08)

e. Applicant's current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. (3-26-08)

02. Temporary Certification. (3-26-08)

a. At the Board's discretion, and pending completion of the competency evaluation and receipt of the criminal background report, a temporary certification may be issued to an applicant who meets all other requirements ~~*and is waiting for the federal criminal background report*~~. ~~*(3-26-08)*~~(11-5-10)T

b. Temporary certification is valid for six (6) months from the date of issuance or until a permanent certification is issued or denied, whichever occurs first. (3-26-08)

c. The applicant must pay the temporary certification fee established in Section 498 of these rules. (3-26-08)

03. Denial of Certification. Certification as a medication assistant - certified may be denied for any of the following grounds: (3-26-08)

a. Failure to meet any requirement established by statute or these rules; or (3-26-08)

~~***e***~~**b.** False representation of facts on an application for certification; or (3-26-08)

~~***b***~~**c.** Failure to pass ~~*the*~~ any certification examination required by the Board; or ~~*(3-26-08)*~~(11-5-10)T

d. Having another person appear in his place for ~~*the*~~ any certification examination required by the Board; or ~~*(3-26-08)*~~(11-5-10)T

e. Engaging in any conduct which would be grounds for discipline under Section 54-1406A, Idaho Code, or these rules; or (3-26-08)

f. Revocation, suspension, limitation, reprimand, voluntary surrender, or any other disciplinary action or proceeding including investigation against a certificate to practice by another state or jurisdiction. (3-26-08)

04. Notification. If certification is denied, the Board will notify the applicant in writing of the reason for denial and inform him of his procedural rights under the Idaho Administrative Procedures Act. (3-26-08)