HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2012 Legislative Session

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.01 - EMERGENCY MEDICAL SERVICES (EMS) -- ADVISORY COMMITTEE (EMSAC)

DOCKET NO. 16-0101-1101 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1003 and 56-1023, Idaho Code.

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

The current EMS rules establish a statewide EMS Advisory Committee (EMSAC) to provide counsel to the Department in administering the Emergency Medical Services Act (Sections 56-1011 through 56- 1023, Idaho Code).

The membership requirements and organizational representation on the EMSAC are being updated in these rules to reflect the addition of the Idaho Transportation Department. The Department is writing this new chapter to provide the representation on the committee, and the committee's duties and responsibilities.

Under Section 56-1013A, Idaho Code, the Idaho EMS Physician Commission was created and assumed responsibility for the provider scopes of practice from the Board of Medicine. Because of this change, the representation of the Board of Medicine is being removed from the EMS Advisory Committee and replaced with representation from the Idaho Transportation Department (ITD), Office of Highway Operations and Safety, since the majority of EMS requests for services are related to traffic accidents.

This new chapter of rules will provide the following for EMS Advisory Committee:

1. **Establish the required membership and organizational representation, including the addition of the Idaho Transportation Department (ITD), and removal of the Idaho Board of Medicine representation;**
2. **Provide length of terms of membership;**
3. **Provide guidelines, duties, and responsibilities of the committee; and**
4. **Provide definitions and other required sections needed to meet APA requirements for rules.**

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 6, 2011, Idaho Administrative Bulletin, Vol. 11-7, pages 42 through 47.

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

This rulemaking has no fiscal impact to the state general fund. The Emergency Medical Services (EMS) program is funded through dedicated funds.

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

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Tuesday, August 2, 2011 at 6:00 p.m. (Local)	
Central Fire District **697 Annis Hwy.** **Rigby, ID**	**Kamiah Emergency Services** **515 Main Street** **Kamiah, ID**

Wednesday, August 3, 2011 at 6:00 p.m. (Local)	
Caribou County Fire Station **665 E. 2nd S.** **Soda Springs, ID**	**New Meadows Fire Station** **200 Hwy. 95** **New Meadows, ID**

Thursday, August 4, 2011 at 6:00 p.m. (Local)	
Jerome City Fire/Rescue **110 W. Yakima Ave.** **Jerome, ID**	**EMS Bureau Conf. Rm. B25** **LBJ Office Bldg. 650 W. State St.** **Boise, ID**

Friday, August 5, 2011 at 6 p.m. (Local)	Saturday, August 6, 2011 at 6 p.m. (Local)
Bonner County EMS **521 3rd Ave.** **Sandpoint, ID**	**Moscow Fire Station #3** **229 Pintail Ln.** **Moscow, ID**

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

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

The current EMS rules establish a statewide EMS Advisory Committee (EMSAC) to provide counsel to the Department in administering the Emergency Medical Services Act (Sections 56-1011 through 56- 1023, Idaho Code).

The membership requirements and organizational representation on the EMSAC need to be updated in these rules to reflect the addition of the Idaho Transportation Department. The Department is writing this new chapter to provide the representation on the committee, and the committee's duties and responsibilities.

Under Section 56-1013A, Idaho Code, the Idaho EMS Physician Commission was created and assumed responsibility for the provider scopes of practice from the Board of Medicine. Because of this change, the representation of the Board of Medicine will be removed from the EMS Advisory Committee and replaced with representation from the Idaho Transportation Department (ITD), Office of Highway Operations and Safety, since the majority of EMS requests for services are related to traffic accidents.

This new chapter of rules will provide the following for EMS Advisory Committee:

5. **Establish the required membership and organizational representation, including the addition of the Idaho Transportation Department (ITD), and removal of the Idaho Board of Medicine representation;**
6. **Provide length of terms of membership;**
7. **Provide guidelines, duties, and responsibilities of the committee; and**
8. **Provide definitions and other required sections needed to meet APA requirements for rules.**

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

described herein: N/A

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

This rulemaking has no fiscal impact to the state general fund. The Emergency Medical Services (EMS) program is funded through dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The "Notice of Intent to Promulgate Rules - Negotiated Rulemaking," was published in the March 2, 2011, Idaho Administrative Bulletin, Vol. 11-3, pages 14 and 15.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 12, 2011.

DATED this 3rd day of June, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0101-1101

IDAPA 16
TITLE 01
CHAPTER 01

16.01.01 - EMERGENCY MEDICAL SERVICES (EMS) -- ADVISORY COMMITTEE (EMSAC)

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Section 56-1023, 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. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.01, "Emergency Medical Services (EMS) -- Advisory Committee (EMSAC)." ( )

02. Scope. These rules define the membership duties and responsibilities of the Emergency Medical Services Advisory Committee. ( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. ( )

003. ADMINISTRATIVE APPEALS.
All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
There are no documents incorporated by reference into this chapter of rules. ( )

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

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

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

03. Street Address. ( )

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ( )

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

04. Telephone. ( )

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ( )

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

05. Internet Websites. ( )

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

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

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT REQUESTS.

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter of rules the following terms apply: ( )

01. Emergency Medical Services Advisory Committee (EMSAC). The statewide advisory board of the EMS Bureau whose members are appointed by the Director of the Idaho Department of Health and Welfare to provide counsel to the Department on administering the EMS Act. ( )

02. Third Service. An EMS agency that is neither fire- nor law enforcement-based. ( )

011. -- 099. (RESERVED)

Statewide EMS Advisory Committee
(Sections 100 through 130)

100. APPOINTMENT OF EMS ADVISORY COMMITTEE AND TERMS OF SERVICE.
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. ( )

101. -- 109. (RESERVED)

110. EMS ADVISORY COMMITTEE MEMBERSHIP.
The Statewide EMS Advisory Committee must include the following representatives: ( )

01. Idaho Transportation Department. One (1) representative recommended by the

Idaho Transportation Department, Office of Highway Operations and Safety. ( )

02. American College of Emergency Physicians (ACEP). One (1) representative recommended by the Idaho Chapter of American College of Emergency Physicians (ACEP). ( )

03. American College of Surgeons. One (1) representative recommended by the Committee on Trauma of the Idaho Chapter of the American College of Surgeons. ( )

04. Idaho Board of Nursing. One (1) representative recommended by the Idaho Board of Nursing. ( )

05. Idaho Medical Association. One (1) representative recommended by the Idaho Medical Association. ( )

06. Idaho Hospital Association. One (1) representative recommended by the Idaho Hospital Association. ( )

07. Idaho Association of Counties. One (1) representative of local government recommended by the Idaho Association of Counties. ( )

08. Career Third Service EMS/Ambulance Service. One (1) representative of a Career Third Service EMS/Ambulance Service. ( )

09. Volunteer Third Service EMS/Ambulance Service. One (1) representative of a volunteer third service EMS/ambulance service. ( )

10. Third Service Nontransport EMS Service. One (1) representative of a third service nontransport EMS service. ( )

11. Idaho Fire Chiefs Association. One (1) representative of a fire department-based EMS/ambulance service recommended by the Idaho Fire Chiefs Association. ( )

12. Fire Department-Based Nontransport EMS Service. One (1) representative of a fire department-based nontransport EMS service. ( )

13. Air Medical Service. One (1) representative of an air medical service. ( )

14. Emergency Medical Technician. One (1) Emergency Medical Technician who represents the interests of Idaho personnel licensed at that level. ( )

15. Advanced Emergency Medical Technician. One (1) Advanced Emergency Medical Technician who represents the interests of Idaho personnel licensed at that level. ( )

16. Paramedic. One (1) paramedic who represents the interests of Idaho personnel licensed at that level. ( )

17. Administrative County EMS Director. One (1) representative who is an

Administrative County EMS Director. ( )

18. EMS Instructor. One (1) EMS instructor who represents the interests of Idaho EMS educators and evaluators. ( )

19. Consumer. One (1) Idaho citizen with experience involving EMS; ( )

20. Private EMS Ambulance Service. One (1) representative of a private EMS ambulance service. ( )

21. American Academy of Pediatrics. One (1) pediatrician who represents the interests of children in the EMS system recommended by the Idaho Chapter of the American Academy of Pediatrics. ( )

22. Pediatric Emergency Medicine Physician. One (1) board-certified, or equivalent, Pediatric Emergency Medicine Physician. ( )

111. -- 119. (RESERVED)

120. RESPONSIBILITIES OF THE EMS ADVISORY COMMITTEE.
The EMS Advisory Committee will meet at least annually, or as needed, for the purposes of: ( )

01. Reviewing Policies and Procedures. Reviewing policies and procedures for provision of emergency medical services and recommending same to the EMS Bureau; ( )

02. Establishing Standard Protocols for EMS Personnel to Respond to Advance DNR Directives. The protocols will be reviewed at least annually to determine if changes in protocol need to be made in order to reflect technological advances. ( )

03. Reviewing Educational Curricula and Standards. Reviewing EMS education curricula, education standards, and examination processes and recommending same to the EMS Bureau. ( )

04. Personnel Licensing Policies and Standards. Making recommendations to the EMS Bureau regarding implementation of personnel licensing policy and standards. ( )

05. Reviewing Grant Applications. Reviewing grant applications and making recommendations for eligibility and awards for the dedicated grant funds program in accordance with IDAPA 16.02.04, "Rules Governing Emergency Medical Services Account III Grants," Section 300. ( )

06. Ambulance and Nontransport Services. Reviewing and making recommendations on the licensing of ambulance and of nontransport services in Idaho. ( )

121. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.07 - EMERGENCY MEDICAL SERVICES (EMS) -- PERSONNEL LICENSING REQUIREMENTS

DOCKET NO. 16-0107-1101 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified by this notice.

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

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

The Department updated the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department reorganized the EMS rules. This chapter of rule is part of that reorganization and provides for personnel licensing requirements.

Based on input received following implementation of this chapter, the text of the pending rule has been amended to clarify a number of sections. Amendments include: A description of the process by which an individual can regain an EMS personnel license after it has been lapsed for more than two years, removal of the reference to the certificate of eligibility (COE) from a section in which it did not belong, and other housekeeping changes and small additions of clarifying language. The complete text of the proposed rule was published in the July 6, 2011, Idaho Administrative Bulletin, Vol. 11-7, pages 48 through 69**.**

Other dockets publishing in this bulletin related to the reorganization of EMS services are: 16-0203-1101, 16-0107-1102, 16-0112-1101, and 16-0101-1101.

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. The Emergency Medical Services (EMS) program is funded through dedicated funds.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into

this rule:

The Department incorporated by reference the "Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual," edition 2012-1, because this manual sets the scope of practice for Emergency Medical Services in Idaho.

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

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of this temporary rule is **July 1, 2011**.

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

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

Tuesday, August 2, 2011 at 6:00 p.m. (Local)	
Central Fire District **697 Annis Hwy.** **Rigby, ID**	**Kamiah Emergency Services** **515 Main Street** **Kamiah, ID**

Wednesday, August 3, 2011 at 6:00 p.m. (Local)	
Caribou County Fire Station **665 E. 2nd S.** **Soda Springs, ID**	**New Meadows Fire Station** **200 Hwy. 95** **New Meadows, ID**

Thursday, August 4, 2011 at 6:00 p.m. (Local)

Jerome City Fire/Rescue **110 W. Yakima Ave.** **Jerome, ID**	**EMS Bureau Conf. Rm. B25** **LBJ Office Bldg. 650 W. State St.** **Boise, ID**

Friday, August 5, 2011 at 6 p.m. (Local)	**Saturday, August 6, 2011 at 6 p.m. (Local)**
Bonner County EMS **521 3rd Ave.** **Sandpoint, ID**	**Moscow Fire Station #3** **229 Pintail Ln.** **Moscow, ID**

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

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

The Department is updating the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department is reorganizing the EMS rules. This new chapter of rule in IDAPA 16.01.07, is part of that reorganization and provides for the licensing of EMS personnel:

1. **Standards and requirements for personnel licensure;**
2. **Application process;**
3. **Scope of practice including definitions and terminology for best practice of national standards;**
4. **Records management,**
5. **References to chapters for complaints, investigations, compliance and enforcement of these rules; and**
6. **Required sections for rule requirements of the Administrative Procedures Act.**

Other dockets publishing in this bulletin that implement the reorganization of EMS services are: 16-0203-1101, 16-0107-1102, 16-0112-1101, and 16-0101-1101.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of these rules are appropriate in order to protect the public health, safety or welfare.

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

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

This rulemaking has no fiscal impact to the state general fund. The Emergency Medical Services (EMS) program is funded through dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was conducted over several years. The negotiated rulemaking notice for this rulemaking published in the March 2, 2011, Idaho Administrative Bulletin, Vol. 11-3, page 14, **under the current rule, IDAPA 16.02.03, "Emergency Medical Services," Docket No. 16-0203-1101**.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The Department incorporated by reference the "Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual," edition 2011-1, because this manual sets the scope of practice for Emergency Medical Services in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 12, 2011.

DATED this 3rd day of June, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0107-1101

IDAPA 16
TITLE 01
CHAPTER 07

16.01.07 -- EMERGENCY MEDICAL SERVICES (EMS) -- PERSONNEL LICENSING REQUIREMENTS

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service

program. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

02. Scope. These rules include requirements and standards for certification and licensure of emergency medical personnel, the establishment of fees for licensure, renewals of licensure, and education criteria for needed skills to perform duties of specific types of licensure. Emergency medical personnel licensed under these rules work or provide EMS services for agencies licensed by the state. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. ( )

003. ADMINISTRATIVE APPEALS.
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the "Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual," edition 2012-1. Copies of this Standards Manual may be obtained from the EMS Bureau described in Section 005 of these rules, or online at: http://www.emspc.dhw.idaho.gov. ( )

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

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

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

03. Street Address. ( )

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ( )

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

04. Telephone. ( )

a. The telephone number for the Idaho Department of Health and Welfare is (208)

334-5500. ( )

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

05. Internet Websites. ( )

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

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

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Licensed EMS personnel must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," to include: ( )

01. Initial Licensure. An individual applying for initial licensure described in Section 110 of these rules. ( )

02. Reinstatement of Licensure. An individual applying for reinstatement of licensure described in Section 131 of these rules. ( )

03. Certificate of Eligibility. An individual applying for a certificate of eligibility described in Section 150 of these rules. ( )

04. Additional Criminal Background Check. The EMS Bureau may require an updated or additional criminal background check at any time, without expense to the candidate, if there is cause to believe new or additional information will be disclosed. ( )

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter of rules, the following terms apply: ( )

01. Advanced Emergency Medical Technician (AEMT). An AEMT is a person

who: ( )

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

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

c. Carries out the practice of emergency medical care within the scope of practice for AEMT determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission;" and ( )

d. Practices under the supervision of a physician licensed in Idaho. ( )

02. Affiliation. The formal association that exists between an agency and those licensed personnel who appear on the agency's roster, which includes active participation, collaboration, and involvement. Affiliation can be demonstrated by the credentialing of licensed personnel by the agency medical director. ( )

03. EMS Agency. Any organization required to be licensed under the provisions in IDAPA 16.02.03, "Emergency Medical Services," by the EMS Bureau that operates an air medical service, ambulance service, or nontransport service. ( )

04. Board. The Idaho Board of Health and Welfare. ( )

05. Candidate. Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code. ( )

06. Certificate of Eligibility. Documentation that an individual is eligible for affiliation with an EMS agency, having satisfied all requirements for an EMS Personnel Licensure except for affiliation, but is not licensed to practice. ( )

07. Commission. The Idaho Emergency Medical Services Physician Commission. ( )

08. Competency. The expected behavior, skill performance and knowledge identified in the description of the profession and the allowable skills and interventions as defined by the scope of practice in the EMS Physicians Commissions Standards Manual incorporated in Section 004 of these rules. ( )

09. Department. The Idaho Department of Health and Welfare. ( )

10. Emergency Medical Care. The care provided to a person suffering from 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. ( )

11. Emergency Medical Responder (EMR). An EMR is a person who: ( )

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

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

c. Carries out the practice of emergency medical care within the scope of practice for EMR determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and ( )

d. Practices under the supervision of a physician licensed in Idaho. ( )

12. Emergency Medical Services (EMS). The services 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. ( )

13. EMS Bureau. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. ( )

14. Emergency Medical Technician (EMT). An EMT is a person who: ( )

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

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

c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and ( )

d. Practices under the supervision of a physician licensed in Idaho. ( )

15. Licensed Personnel. Those individuals who are emergency medical responders, emergency medical technicians, advanced emergency medical technicians, and paramedics. ( )

16. 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 licensure. ( )

17. Paramedic. A paramedic is a person who: ( )

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

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

c. Carries out the practice of emergency medical care within the scope of practice for paramedic determined by the Idaho Emergency Medical Services Physicians Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission"; and ( )

d. Practices under the supervision of a physician licensed in Idaho. ( )

18. Patient. A sick, injured, incapacitated, or helpless person who is under medical care or treatment. ( )

19. Patient Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. ( )

20. Patient Care. The performance of acts or procedures under emergency conditions 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. ( )

21. Skills Proficiency. The process overseen by an EMS agency medical director to verify competency in psychomotor skills. ( )

22. 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: establishing standing orders and protocols, reviewing performance of licensed personnel, providing instructions for patient care via radio or telephone, and other oversight. ( )

23. State Health Officer. The Administrator of the Division of Public Health. ( )

011. -- 074. (RESERVED)

075. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS PERSONNEL.

01. Method of Treatment. EMS personnel must practice medically acceptable methods of treatment and must not endeavor to extend their practice beyond their competence and the authority vested in them by the medical director. ( )

02. Commitment to Self-Improvement. EMS personnel must continually strive to increase and improve their knowledge and skills and render to each patient the full measure of their abilities. ( )

03. Respect for the Patient. EMS personnel must provide all services with respect for

the dignity of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. ( )

04. Confidentiality. EMS personnel must hold in strict confidence all privileged information concerning the patient except as disclosure or use of this information is permitted or required by law or Department rule. ( )

05. Conflict of Interest. EMS personnel must not accept gratuities for preferential consideration of the patient and must guard against conflicts of interest. ( )

06. Professionalism. EMS personnel must uphold the dignity and honor of the profession and abide by its ethical principles and should be familiar with existing laws governing the practice of emergency medical services and comply with those laws. ( )

07. Cooperation and Participation. EMS personnel must cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public. ( )

08. Ethical Responsibility. EMS personnel must refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. ( )

076. -- 099. (RESERVED)

Personnel Licensure Requirements
(Sections 100-199)

100. PERSONNEL LICENSURE REQUIRED.
Any individual who provides emergency medical care must obtain and maintain a current EMS personnel license issued by the EMS Bureau, or recognition by the EMS Bureau described under Section 140 of these rules. The levels of Idaho personnel licensure are: ( )

01. Emergency Medical Responder (EMR). ( )

02. Emergency Medical Technician (EMT). ( )

03. Advanced Emergency Medical Technician (AEMT). ( )

04. Paramedic. ( )

101. AFFILIATION REQUIRED TO PRACTICE.
Licensed EMS personnel must be affiliated with an EMS agency, and only practice under the supervision of the agency medical director as required in IDAPA 16.02.02, "Rules of the Idaho EMS Physician Commission." ( )

102. -- 104. (RESERVED)

105. APPLICATION AND INSTRUCTIONS FOR EMS PERSONNEL LICENSURE.
A personnel license or certificate of eligibility application and instructions may be obtained from the EMS Bureau described in Section 005 of these rules, or online at: http://www.idahoems.org. ( )

106. TIME FRAME FOR PERSONNEL LICENSURE AFTER SUCCESSFUL COMPLETION OF EDUCATION COURSE.
An individual who has successfully completed an EMS education course is eligible to attempt the certification examination for the appropriate level of licensure. ( )

01. Complete Standardized Certification Examination. A candidate must successfully complete all components of the standardized certification examination *in a twelve (12) month period* within twenty-four (24) months of completing an EMS training course in order to be eligible for an Idaho EMS personnel license. *( )*

02. Certification Examination Not Completed. If all components of the standardized certification examination are not *successfully* completed *in a twelve (12) month period* within twenty-four (24) months of course completion, the candidate must repeat the initial training course and all components of the certification examination in order to be eligible for an Idaho EMS personnel license. *( )*

106. -- 109. (RESERVED)

110. INITIAL PERSONNEL LICENSURE.
Upon successful completion of an approved course recognized by the EMS Bureau under IDAPA 16.02.03, "Emergency Medical Services," an individual may apply to the EMS Bureau for licensure. The candidate must meet the following: ( )

01. Candidate Age Requirements. An individual applying for licensure must meet the following age requirements: ( )

a. An EMR and EMT candidate must be either sixteen (16) or seventeen (17) years old with parental or legal guardian consent, or eighteen (18) years old. ( )

b. An AEMT and Paramedic candidate must be eighteen (18) year old. ( )

02. Declaration of Previous Applications and Licensures. A candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification. ( )

03. Authorization for Release of Information. A candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. ( )

04. Provide Current Affiliation with EMS Agency. A candidate must declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have *a c*urrent affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. *( )*

05. Valid Identification. A candidate must have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the Armed Forces of the United States. ( )

06. Criminal History and Background Check. A candidate must successfully complete a criminal history and background check according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial or revocation of licensure. ( )

07. Pass Standardized Examination. A candidate must successfully complete the standardized examination for the level of licensure on the application required under IDAPA 16.02.03, "Emergency Medical Services." ( )

a. A candidate for EMR licensure must have successfully completed the standardized certification examination at the EMR level *or higher* within the preceding thirty-six (36) months. *( )*

b. A candidate for EMT licensure must have successfully completed the standardized certification examination at the EMT level *or higher* within the preceding thirty-six (36) months. *( )*

c. A candidate for AEMT licensure must have successfully completed the standardized certification examination at the *AEMT* level *or higher* within the preceding twenty-four (24) months. *( )*

d. *A candidate for Paramedic licensure must have successfully completed the standardized certification examination at the Paramedic level within the preceding twenty-four (24) months.* *( )*

08. Standardized Exam Attempts For Initial Licensure. A candidate for initial licensure is allowed to attempt to successfully pass the standardized exam as follows: ( )

a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. ( )

b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three

(3) attempts are allowed. ( )

09. Submit Required Licensure Fee. A candidate must submit the applicable initial licensure fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. ( )

111. -- 114. (RESERVED)

115. EMS PERSONNEL LICENSE DURATION.
Duration of a personnel license is determined using the following specified time intervals. ( )

01. Initial License Duration for EMR and EMT Level Licensure. EMR and EMT personnel licenses expire on March 31 or September 30. Expiration dates for EMR and EMT initial licenses are set for not less than thirty-six (36) months and not more than forty-two (42) months from the date of successful certification examination completion in order to establish an expiration date of March 31 or September 30. ( )

02. Initial License Duration for AEMT and Paramedic Level Licensure. AEMT and Paramedic personnel licenses expire on March 31 or September 30. Expiration dates for AEMT and Paramedic initial licenses are set for not less than twenty-four (24) months and not more than thirty (30) months from the date of successful certification examination completion in order to establish an expiration date of March 31 or September 30. ( )

03. EMS Personnel License Renewal Duration for EMR and EMT Level Licensure. An EMR and EMT level personnel license is renewed for three (3) years. ( )

04. EMS Personnel License Renewal Duration for AEMT and Paramedic Level Licensure. An AEMT and Paramedic level personnel license is renewed for two (2) years.( )

116. PERSONNEL LICENSE TRANSITION.
Between the years of 2011 and 2016, the scope of practice and the accompanying license levels for EMS personnel will change. The scope of practice for licensed EMS personnel is provided in the EMS Physician Commission Standards Manual incorporated by reference under Section 004 of these rules. Personnel licensed at the AEMT level can opt to either transition to the AEMT-2011 level, or they may remain at the AEMT-1985 level. In order to renew a license, personnel licensed at the EMR, EMT, or Paramedic level must transition and meet the following requirements. ( )

01. General Transition Requirements for Licensed Personnel. Licensed personnel transitioning to a new licensure level must: ( )

a. Successfully complete an Idaho-approved transition course appropriate for the level of licensure; ( )

b. Provide documentation of verification by the course physician of competency in the knowledge and skills identified in the appropriate transition course curriculum; and ( )

c. Include proof of completion of transition requirements with the license renewal

application. All other license renewal requirements listed in Section 120 of these rules must be completed. The transition course may be counted towards the renewal continuing education requirements. ( )

02. Transition Options Specific for Personnel Licensed at the AEMT Level. Personnel licensed at the AEMT level have options specific to transitioning as follows: ( )

a. In addition to the general transition requirements under Subsection 116.01 of this rule, personnel licensed at the AEMT level may choose to transition to the AEMT-2011. To transition to the AEMT-2011 level, the applicant must successfully pass the Idaho-approved written and practical examinations for that level of licensure by the deadlines provided in Subsection 116.03.b of this rule. ( )

b. Personnel licensed at the AEMT level who choose not to complete the transition requirements according to Subsection 116.03.b. of this rule, will be allowed to renew their personnel license at the AEMT-1985 level, if all other license renewal requirements listed in Section 120 of these rules are met. *( )*

03. Application Deadlines for Transition of Licensed Personnel. Licensed personnel who choose to transition must submit an "EMS Personnel License Transition Application" according to the following deadline dates: ( )

a. For personnel licensed at the EMR and EMT levels, an application for transition must be submitted after January 1, 2012, and before September 30, 2016, according to the effective date of the initial license or renewal date provided in the table below:

Table 116.03.a.
PERSONNEL LICENSED AT EMR AND EMT LEVELS - TRANSITION DEADLINE DATES

Effective Date of Initial License	Date Transition Requirements MUST be Completed
April 1, 2011 - September 30, 2011	September 30, 2014
October 1, 2011 - December 31, 2011	March 31, 2015

Effective Date of Renewed License	Date Transition Requirements MUST be Completed
April 1, 2011	March 31, 2014
October 1, 2011	September 30, 2014
April 1, 2012	March 31, 2015
October 1, 2012	September 30, 2015
April 1, 2013	March 31, 2016
October 1, 2013	September 30, 2016

( )

b. For personnel licensed at the AEMT and Paramedic levels, an application for transition must be submitted after January 1, 2013, and before September 30, 2015, according to

the effective date of the initial license or renewal date provided in the table below:

Table 116.03.b.
PERSONNEL LICENSED AT AEMT AND PARAMEDIC LEVELS - TRANSITION DEADLINE DATES

Effective Date of Initial License	Date Transition Requirements MUST be Completed
April 1, 2012 - September 30, 2012	September 30, 2014
October 1, 2012 - December 31, 2012	March 31, 2015

Effective Date of Renewed License	Date Transition Requirements MUST be Completed
April 1, 2012	March 31, 2014
October 1, 2012	September 30, 2014
April 1, 2013	March 31, 2015
October 1, 2013	September 30, 2015

( )

04. Early Transition of Licensed Personnel. Licensed personnel who meet all transition requirements and choose to transition prior to their license renewal date will be issued a license as follows: ( )

a. Continuing education completed between the effective *date of the pre-transition license* and the expiration date of the *transitioned* license may be used to meet requirements listed in Section 120 of these rules for renewal of the transition license; *( )*

b. The new license will have the same expiration date as the current license; and ( )

c. The new license will have a new effective date, based on the date the transition was approved by the EMS Bureau. ( )

117. -- 119. (RESERVED)

120. PERSONNEL LICENSE RENEWAL.
Licensed personnel must provide documentation that they meet the following requirements: ( )

01. Documentation of Affiliation with EMS Agency. A candidate applying for renewal of licensure must be affiliated with a licensed EMS agency which functions at, or above, the level of licensure being renewed. Documentation that the license holder is currently credentialed or undergoing credentialing by an affiliating EMS agency medical director must be submitted as assurance of affiliation for license renewal. ( )

02. Documentation of Continuing Education for Level of Licensure Renewal. A candidate for renewal of licensure must provide documentation of continuing education

consistent with the license holder's level of licensure. All continuing education and skill proficiency requirements must be completed under the provisions in Sections 300 through 335 of these rules. The time frame for continuing education courses must meet the following requirements: ( )

a. All continuing education and skill proficiency requirements for renewal of an initial Idaho personnel license must be completed as follows: ( )

i. For EMR or EMT, within the thirty-six (36) months preceding renewal. ( )

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding renewal. ( )

b. All continuing education and skill proficiency requirements for successive licenses must be completed between the effective and expiration dates of the license being renewed *or according to Section 116 of these rules*. *( )*

c. All continuing education and skill proficiency requirements for renewal of licenses obtained through conversion of a Certificate of Eligibility must be completed as follows: ( )

i. For EMR or EMT, within the thirty-six (36) months preceding renewal. ( )

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding renewal. ( )

03. Declarations of Convictions or Adjudications. A candidate for renewal of licensure must provide a declaration of any misdemeanor or felony adjudications. ( )

04. Time Frame for Application of Licensure Renewals. Documentation of license renewal requirements is due to the EMS Bureau prior to the license expiration date. Failure to submit a complete renewal application by the license expiration date renders the license invalid and the individual must not practice or represent himself as a license holder. ( )

05. Submit Required Licensure Renewal Fees. A candidate must submit the applicable license renewal fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. ( )

121. -- 124. (RESERVED)

125. SUBMISSION OF EMS PERSONNEL LICENSURE APPLICATION AND DOCUMENTATION.
Each EMS personnel license holder or candidate is responsible for meeting license renewal requirements and submitting completed license renewal documentation to the EMS Bureau by the current license expiration date. ( )

01. Earliest Submission Date for License Renewal. Licensed EMS personnel may submit renewal application and documentation to the EMS Bureau up to six (6) months prior to the current license expiration date. ( )

02. EMS Personnel License Expiration Date Falls on a Non-Work Day. When a license expiration date falls on a weekend, holiday, or other day the EMS Bureau is closed, the EMS Bureau will accept applications until the close of the next regular business day following the non-work day. ( )

126. -- 129. (RESERVED)

130. LAPSED LICENSE.
Licensed personnel who fail to submit a complete renewal application prior to the expiration date of their license cannot practice or represent themselves as licensed EMS personnel. ( )

01. Failure to Submit an Application and Renewal Documentation. No grace periods or extensions to an expiration date may be granted. After the expiration date the EMS personnel license will no longer be valid. ( )

02. Application Under Review by the EMS Bureau. Provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline, a personnel license does not lapse while under review by the EMS Bureau. ( )

03. Failure to Provide Application Information Requested by the EMS Bureau. After the expiration date of a license, a candidate for license renewal who does not provide the information requested by the EMS Bureau within twenty-one (21) days from the date of notification to the last known address, will be considered to have a lapsed license. ( )

04. Reinstatement of Lapsed EMS Personnel License. In order to reinstate at lapsed license, a candidate must submit an application for license reinstatement to the EMS Bureau within twenty-four (24) months of the expiration date of the lapsed license. ( )

05. Reinstatement of an EMS Personnel License Lapsed for More Than Twenty-Four Months. *An individual whose license has been lapsed for more than twenty-four (24) months must retake and successfully complete an initial education course for the level of licensure for reinstatement. The individual must then meet all requirements in Section 110 of these rules for an initial personnel license.* *( )*

131. REINSTATEMENT OF A LAPSED EMS PERSONNEL LICENSE.
An individual desiring to reinstate a lapsed personnel license must provide documentation that he meets the following requirements: ( )

01. ***Declaration of Previous Applications and Licensures***. *A reinstatement candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification.* *( )*

02. Authorization for Release of Information. *A reinstatement candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau.*
( )

03. Provide Current Affiliation with EMS Agency. *A reinstatement candidate must declare all organizations in which they are allowed to practice as licensed personnel. The candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate.* *( )*

04. Documentation of Continuing Education for Lapsed License Reinstatement. A candidate for reinstatement of a lapsed license must provide documentation of continuing education consistent with the license holder's lapsed license. Continuing education requirements are provided in Sections 300 through 335 of these rules. The time frame for meeting the continuing education requirements for reinstatement are as follows: ( )

a. The candidate must meet continuing education requirements under Sections 320 through 335 of these rules for the last valid licensure cycle; and ( )

b. Additional continuing education hours in any combination of categories and venues, proportionate to the amount of time since the expiration date of the lapsed license, as follows: ( )

i. EMR -- Three-quarters (3/4) of one (1) hour of continuing education per month of lapsed time. ( )

ii. EMT -- One and one-half (1 ½) hours of continuing education per month of lapsed time. ( )

iii. AEMT -- Two and one-quarter (2 ¼) hours of continuing education per month of lapsed time. ( )

iv. Paramedic -- Three (3) hours of continuing education per month of lapsed time. ( )

05. Valid Identification for Reinstatement of Lapsed License. A reinstatement candidate must have a valid 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. ( )

06. Criminal History and Background Check for Reinstatement of Lapsed License. A reinstatement candidate must successfully complete a criminal background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under IDAPA 16.05.06 will result in denial of reinstatement of licensure. ( )

07. Pass Standardized Examination for Reinstatement. A reinstatement candidate must successfully complete the standardized examination for the lapsed level of licensure required under IDAPA 16.02.03, "Emergency Medical Services." A candidate for reinstatement must successfully complete the standardized certification examination within the time period during which the license was lapsed. ( )

08. Standardized Exam Attempts For Reinstatement. A candidate for licensure

reinstatement is allowed to attempt to successfully pass the standardized exam as follows: *( )*

a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. ( )

b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three (3) attempts are allowed. ( )

0*9*. Submit Required Licensure Fee for Reinstatement. A candidate must submit the applicable reinstatement license fee provided in Section 111 of these rules. A candidate for reinstatement of an EMR or EMT level of licensure has no fee requirement. ( )

***10*. Expiration Date of a Reinstated License**. The expiration date for a lapsed license that is reinstated is determined as provided in Section 115 of these rules. ( )

11. Reinstatement During Transition. *A candidate may reinstate his lapsed license only if he has completed transition requirements for his level of licensure. Education obtained in a transition course may be used to meet the CEU requirements for reinstatement according to Section 300 of these rules.* *( )*

132. -- 139. (RESERVED)

140. RECOGNITION OF REGISTRATION, CERTIFICATION OR LICENSURE FROM OTHER JURISDICTIONS.

01. EMS Personnel Licensed or Certified in Other States. An individual, possessing an EMS personnel license or certification from a state other than Idaho, must have prior recognition or reciprocity granted by the EMS Bureau prior to providing emergency medical care in Idaho. The following applies: ( )

a. An individual certified or licensed in a state that has an interstate compact with Idaho that allows reciprocal recognition of EMS personnel may practice as licensed personnel as defined in the interstate compact. ( )

b. An individual who is currently licensed or certified by another State to provide emergency medical care can apply to the EMS Bureau for limited recognition to practice in Idaho. Limited recognition does not grant an individual the ability to practice outside of those specified and approved by the EMS Bureau. ( )

c. An individual, possessing a current NREMT registration or a current EMS certification or license from another state at or above the level of licensure they are seeking in Idaho, is eligible for an Idaho EMS personnel licensure if they satisfy the requirements in Section 110 of these rules prior to providing emergency medical care in Idaho. ( )

02. Personnel Licensure Candidate Trained in Other States. A candidate trained outside of Idaho must apply for and obtain an Idaho EMS license as required in Section 110 of these rules prior to providing emergency medical care in Idaho. A declaration that the candidate is fully eligible for EMS licensure in the state in which he was trained, must be obtained from the EMS licensing authority in that state and submitted to the EMS Bureau. ( )

03. Individual With a NREMT Registration. An individual possessing only a registration with the National Registry of Emergency Medical Technicians (NREMT) must obtain an Idaho EMS personnel license as required in Section 110 of these rules prior to providing emergency medical care in Idaho. ( )

141. -- 144. (RESERVED)

145. CHANGES TO AN EXISTING LICENSE.

01. Surrender of a Current EMS Personnel License. An individual who possesses a current EMS personnel license may surrender that license at any time by submitting a letter of intent and his license, to the EMS Bureau. ( )

02. Surrender of License to Prevent Investigation or Disciplinary Action. Surrendering or expiration of a license does not prevent an investigation or disciplinary action against the individual. ( )

03. Relinquish a Current EMS Personnel License for a Lower Level License. An individual who possesses a current license may relinquish that license and receive a license at a lower level with the same expiration date as the original license. The individual must have current affiliation with a licensed EMS agency which functions at, or higher than, the level of licensure being sought. ( )

04. Relinquishment of a License to a Lower Level License to Prevent Investigation or Disciplinary Action. Relinquishing a personnel license does not prevent an investigation or disciplinary action against the individual. ( )

05. Reporting Requirements for Changes in Status. Licensed personnel must notify the EMS Bureau within thirty (30) days of a change in name, mailing address, telephone number or agency affiliation. ( )

06. Personnel License Duration Shortened. The EMS Bureau will issue a license with a shortened licensure duration upon the request of the license holder. ( )

146. MULTIPLE LICENSES.
An individual may hold more than one (1) level of personnel licensure in Idaho, but can only

renew one (1) personnel license at one (1) level. ( )

147. -- 149. (RESERVED)

150. CERTIFICATE OF ELIGIBLITY REQUIREMENTS.

01. Personnel Licensure Requirements are Met. An individual, who has successfully completed an approved course, and meets all requirements for EMS personnel licensure required in Section 110 of these rules, except for obtaining an agency affiliation provided in Subsection 110.04 of these rules, may apply to the EMS Bureau for a certificate of eligibility. ( )

02. Certificate of Eligibility Duration. Duration of a certificate of eligibility is determined using the specified time intervals of the personnel licensure level requirements in Section 115 of these rules. ( )

03. Criminal History and Background Check. An individual applying for a certificate of eligibility must successfully complete a criminal history and background check within the six (6) months prior to the issuance or renewal of a certificate of eligibility, according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial of a certificate of eligibility. ( )

04. Renewal of Certificate of Eligibility. An individual must provide documentation that the following requirements have been met in order to renew a certificate of eligibility: ( )

a. Continuing education requirements for the level of licensure listed under the license renewal requirements in Section 120 of these rules have been met; and ( )

b. Successful completion of the standardized examination designated by the EMS Bureau for the certificate of eligibility. ( )

05. Revocation of Certificate of Eligibility. The EMS Bureau will revoke a certificate of eligibility if the certificate holder is determined to no longer meet eligibility requirements or has obtained a personnel license. ( )

151. -- 174. (RESERVED)

175. EMS BUREAU REVIEW OF APPLICATIONS.

01. Review of License Applications. The EMS Bureau reviews each application for completeness and accuracy. Random applications are selected for audit by the EMS Bureau. Applications will also be audited when information declared on the application appears incomplete, inaccurate, or fraudulent. ( )

02. EMS Bureau Review of Renewal Application. A personnel license does not expire while under review by the EMS Bureau, provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline required under

Section 130 of these rules. ( )

176. -- 299. (RESERVED)

Continuing Educational And Skills Proficiency Requirements
For Personnel Licensure
(Sections 300 - 399)

300. CONTINUING EDUCATION AND SKILLS PROFICIENCY.

01. Continuing Education Must Meet Objectives of Initial Course Curriculum. All continuing education and skills proficiency assurance must be consistent with the objectives of the initial course curriculum or be a logical progression of those objectives. ( )

02. Documentation of Continuing Education. Licensed personnel must maintain documentation of all continuing education as follows: ( )

a. An EMR and EMT must maintain documentation of continuing education for four (4) years. ( )

b. An AEMT and Paramedic must maintain documentation of continuing education for three (3) years. ( )

03. Transition to New Scope of Practice. Education required to transition to a new scope of practice must meet the following: ( )

a. Within the same level of licensure, all transition education may count on an hour-for-hour basis in the appropriate categories within a single venue. When transition education hours exceed seventy-five percent (75%) of the total continuing education hours required, all continuing education hours can be in a single venue; and ( )

b. Education must be completed during a single license duration. ( )

04. Continuing Education Records are Subject to Audit. The EMS Bureau reserves the right to audit continuing education records to verify that renewal requirements have been met. ( )

301. -- 304. (RESERVED)

305. CONTINUING EDUCATION CATEGORIES FOR PERSONNEL LICENSURE RENEWAL.

01. Pediatric Assessment and Management. ( )

02. Anatomy and Physiology. ( )

03. Medical Terminology. ( )

04. Pathophysiology. ( )

05. Life Span Development. ( )

06. Public Health. ( )

07. Pharmacology. ( )

08. Airway Management, Ventilation, and Oxygenation. ( )

09. Patient Assessment. ( )

10. Medical Conditions. ( )

11. Shock and Resuscitation. ( )

12. Trauma. ( )

13. Special Patient Populations. Such as bariatric, geriatric, obstetrics, pregnancy, etc. ( )

14. EMS Systems and Operations. ( )

306. -- 309. (RESERVED)

310. VENUES OF CONTINUING EDUCATION FOR PERSONNEL LICENSURE RENEWAL.

01. Structured Classroom Sessions. ( )

02. Refresher Programs. Refresher programs that revisit the original curriculum and have an evaluation component. ( )

03. Nationally Recognized Courses. ( )

04. Regional and National Conferences. ( )

05. Teaching Continuing Education Topics. The continuing education topics being taught must fall under the categories in Section 305 of these rules. ( )

06. Agency Medical Director-Approved Self-Study or Directed Study. This venue is not allowed to be used for a certificate of eligibility continuing education requirement under Section 350 of these rules. ( )

07. Case Reviews and Grand Rounds. ( )

08. Distributed Education. This venue includes distance and blended education using

computer, video, audio, Internet, and CD resources. ( )

09. Journal Article Review with an Evaluation Instrument. ( )

10. Author or Co-Author an EMS-Related Article in a Nationally Recognized Publication. The article must be published in an EMS-specific publication. ( )

311. -- 319. (RESERVED)

320. EMR LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.
An EMR level license renewal candidate must provide documentation of the following during each licensure period. ( )

01. EMR Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of twenty-four (24) hours of continuing education. The types of continuing education courses and the number of hours required for EMR level licensure are: ( )

a. A minimum of two (2) hours in pediatrics; ( )

b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: ( )

i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; ( )

ii. For extrication awareness training, two (2) hours in *classroom presentation, or one (1) hour in* distributed education; *( )*

c. Two (2) hours in six (6) categories *other than pediatrics and EMS Systems and Operations* listed in Section 305 of these rules, for twelve (12) continuing education hours; and *( )*

d. Seven (7) hours of continuing education can be from any single category or combination of categories listed in Section 305 of these rules. *( )*

02. Venues Where Continuing Education May be Taken. Continuing education for personnel licensed at the EMR level must include two (2) of the continuing education venues listed in Section 310 of these rules during each licensure period. ( )

03. Skills Proficiency for EMR Level License Renewal. A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the EMR licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: ( )

a. Recognize and manage acute traumatic and medical life threats or conditions

based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and ( )

b. Specific skills for an EMR that includes: ( )

i. Airway, ventilation, and oxygenation; ( )

ii. Cardiovascular and circulation; ( )

iii. Immobilization; ( )

iv. Medication administration; ( )

v. Normal childbirth; ( )

vi. Patient care reporting documentation; and ( )

vii. Safety and operations. ( )

321. -- 324. (RESERVED)

325. EMT LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.
An EMT level license renewal candidate must provide documentation of the following during each licensure period. ( )

01. EMT Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of forty-eight (48) hours of continuing education. The types of continuing education courses and the number of hours needed for EMT level licensure are: ( )

a. A minimum of four (4) hours in pediatrics; ( )

b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: ( )

i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; ( )

ii. For extrication awareness training, two (2) hours in *classroom presentation, or one (1) hour in* distributed education; *( )*

c. Four (4) hours in eight (8) categories *other than pediatrics and EMS Systems and Operations* listed in Section 305 of these rules for thirty-two (32) hours; and *( )*

d. Nine (9) hours can be from any single category or combination of categories listed in Section 305 of these rules. *( )*

02. Venues Where Continuing Education May be Taken. Continuing education for personnel licensed at the EMT level must include four (4) of the continuing education venues listed in Section 310 of these rules during each licensure period. ( )

03. Skills Proficiency for EMT Level License Renewal. A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the EMT licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: ( )

a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and ( )

b. Specific skills for an EMT that includes: ( )

i. Airway, ventilation, and oxygenation; ( )

ii. Cardiovascular and circulation; ( )

iii. Immobilization; ( )

iv. Medication administration; ( )

v. Normal and complicated childbirth; ( )

vi. Patient care reporting documentation; and ( )

vii. Safety and transport operations. ( )

326. -- 329. (RESERVED)

330. AEMT LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.
An AEMT license renewal candidate must provide documentation of the following during each licensure period: ( )

01. AEMT Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of fifty-four (54) hours of continuing education. The types of continuing education courses and the number of hours needed for AEMT level licensure are: ( )

a. A minimum of six (6) hours in pediatrics; ( )

b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: ( )

i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; ( )

ii. For extrication awareness training, two (2) hours in *classroom presentation, or one (1) hour in* distributed education; *( )*

c. Four (4) hours in nine (9) categories *other than pediatrics and EMS Systems and Operations* listed in Section 305 of these rules, for thirty-six (36) hours; and *( )*

d. Nine (9) hours of continuing education can be from any single category or combination of categories listed in Section 305 of these rules. *( )*

02. Venues Where Continuing Education for AEMT License Renewal May be Taken. Continuing education for personnel licensed at the AEMT level must include four (4) of the continuing education venues listed in Section 310 of these rules during each licensure period. ( )

03. Skills Proficiency for AEMT Level License Renewal. A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the AEMT licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: ( )

a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and ( )

b. Specific skills for an AEMT that includes: ( )

i. Advanced airway, ventilation, and oxygenation; ( )

ii. Cardiovascular and circulation; ( )

iii. Immobilization; ( )

iv. Medication administration; ( )

v. Normal and complicated childbirth; ( )

vi. Patient care reporting documentation; ( )

vii. Safety and transport operations; and ( )

viii. Vascular access. ( )

331. -- 334. (RESERVED)

335. PARAMEDIC LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.

A paramedic license renewal candidate must provide documentation of the following during each licensure period. ( )

01. Paramedic Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of seventy-two (72) hours of continuing education. The types of continuing education courses and the number of hours needed for paramedic level licensure are: ( )

a. A minimum of eight (8) hours in pediatrics; ( )

b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: ( )

i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; ( )

ii. For extrication awareness training, two (2) hours in *classroom presentation, or one (1) hour in* distributed education; *( )*

c. Four (4) hours in eleven (11) categories *other than pediatrics and EMS Systems and Operations* listed in Section 305 of these rules, for forty-four (44) hours; and *( )*

d. Seventeen (17) hours can be from any single category or a combination of categories listed in Section 305 of these rules. *( )*

02. Venues Where Continuing Education for Paramedic Level License Renewal May be Taken. Continuing education for personnel licensed at the paramedic level must include six (6) of the continuing education venues listed in Section 310 of these rules during each licensure period. ( )

03. Skills Proficiency for Paramedic Level License Renewal. A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the Paramedic licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: ( )

a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and ( )

b. Specific skills for a Paramedic that includes: ( )

i. Advanced airway, ventilation, and oxygenation, to include endotracheal intubation; ( )

ii. Cardiovascular and circulation, to include cardiac rhythm interpretation; ( )

iii. Immobilization; ( )

iv. Medication administration, to include parenteral drug administration; ( )

v. Normal and complicated childbirth; ( )

vi. Patient care reporting documentation; ( )

vii. Safety and transport operations; ( )

viii. Vascular access; and ( )

ix. Manual defibrillation. ( )

336. -- 349. (RESERVED)

350. CONTINUING EDUCATION AND SKILLS PROFICIENCY FOR RENEWAL OF CERTIFICATE OF ELIGIBILITY REQUIREMENTS.
A certificate of eligibility renewal candidate must provide documentation demonstrating completion of the following during each period of eligibility. ( )

01. Examination. A candidate must have successfully completed the standardized examination designated by the EMS Bureau for the certificate of eligibility. ( )

02. Continuing Education for Certificate of Eligibility Licensure Level. A candidate must provide proof of successful completion of continuing education hours for the types of continuing education courses, the number of hours needed for a specific certificate of eligibility licensure level, and in the venues as required for the following: ( )

a. EMR licensure level renewal required in Section 320 of these rules. ( )

b. EMT licensure level renewal required in Section 325 of these rules. ( )

c. AEMT licensure level renewal required in Section 330 of these rules. ( )

d. Paramedic licensure level renewal required in Section 335 of these rules. ( )

351. -- 399. (RESERVED)

400. INVESTIGATION OF COMPLAINTS FOR PERSONNEL LICENSING VIOLATIONS.
Investigation of complaints and disciplinary actions for personnel licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

401. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.
Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the

professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

402. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.12 - EMERGENCY MEDICAL SERVICES (EMS) -- COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS

DOCKET NO. 16-0112-1101 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

The Department updated the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department reorganized the EMS rules. This chapter of rule is part of that reorganization and provides for the investigation of complaints and disciplinary actions for licensure and certification. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the July 6, 2011, Idaho Administrative Bulletin, Vol. 11-7, pages 73 through 85**.**

Other dockets published in this bulletin that implemented the reorganization of EMS services are: 16-0203-1101, 16-0107-1101, 16-0107-1102, and 16-0101-1101.

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. The Emergency Medical Services (EMS) program is funded through dedicated funds.

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

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of this temporary rule is **July 1, 2011**.

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

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

Tuesday, August 2, 2011 at 6:00 p.m. (Local)	
Central Fire District **697 Annis Hwy.** **Rigby, ID**	**Kamiah Emergency Services** **515 Main Street** **Kamiah, ID**

Wednesday, August 3, 2011 at 6:00 p.m. (Local)	
Caribou County Fire Station **665 E. 2nd S.** **Soda Springs, ID**	**New Meadows Fire Station** **200 Hwy. 95** **New Meadows, ID**

Thursday, August 4, 2011 at 6:00 p.m. (Local)	
Jerome City Fire/Rescue **110 W. Yakima Ave.** **Jerome, ID**	**EMS Bureau Conf. Rm. B25** **LBJ Office Bldg. 650 W. State St.** **Boise, ID**

Friday, August 5, 2011 at 6 p.m. (Local)	**Saturday, August 6, 2011 at 6 p.m. (Local)**
Bonner County EMS **521 3rd Ave.** **Sandpoint, ID**	**Moscow Fire Station #3** **229 Pintail Ln.** **Moscow, ID**

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

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

The Department is updating the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department is reorganizing the EMS rules. This new chapter of rule in IDAPA 16.01.12, is part of that reorganization and provides for the investigation of complaints and disciplinary actions for licensure and certification as follows:

1. **Requirements for filing complaints, and disclosure of records;**
2. **Requirements for handling investigations of complaints, and compliance with licensing standards;**
3. **Enforcement and disciplinary actions;**
4. **Notification of disciplinary actions,**
5. **References to chapters that these rules provide disciplinary actions and compliance enforcement for; and**
6. **Required sections to meet rule requirements of the** Administrative Procedures Act**.**

Other dockets publishing in this bulletin that implement the reorganization of EMS services are: 16-0203-1101, 16-0107-1101, 16-0107-1102, and 16-0101-1101.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of these rules are appropriate in order to protect the public health, safety or welfare.

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

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

This rulemaking has no fiscal impact to the state general fund. The Emergency Medical Services (EMS) program is funded through dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was conducted over server al years. The negotiated rulemaking for these rules published in the March 2, 2011, Idaho Administrative Bulletin, Vol. 11-3, page 14**, under the current rule, IDAPA 16.02.03, "Emergency Medical Services," Docket No. 16-0203-1101**.

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 Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 12, 2011.

DATED this 3rd day of June, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0112-1101

IDAPA 16
TITLE 01
CHAPTER 12

16.01.12 - EMERGENCY MEDICAL SERVICES (EMS) -- COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Sections 56-1005 and 56-1023, 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. The EMS Bureau is authorized under Section 56-1022, Idaho Code, to manage complaints and investigations, and implement license actions against EMS personnel and agencies, that includes levying fines against an EMS agency. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.12, "Emergency Medical Services (EMS) --Complaints, Investigations, and Disciplinary Actions." ( )

02. Scope. These rules provide for the management of complaints, investigations, enforcement, and disciplinary actions by the EMS Bureau for personnel and agency licensure and certification. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written

statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter.

( )

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.

No documents are incorporated in this chapter of rule. ( )

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

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

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

03. Street Address. ( )

a. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. ( )

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

04. Telephone. ( )

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ( )

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

05. Internet Websites. ( )

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

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

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. ( )

a. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

b. Preliminary investigations and related documents are confidential until a notice of certificate or license action is issued by the EMS Bureau. ( )

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter of rules the following terms apply: ( )

01. Affiliating EMS Agency. The licensed EMS agency, or agencies, under which licensed personnel are authorized to provide patient care. ( )

02. Board. The Board of Health and Welfare. ( )

03. Certified EMS Instructor. An individual approved by the EMS Bureau, who has met the requirements in IDAPA 16.02.03, "Emergency Medical Services," to provide EMS education and training. ( )

04. Department. The Idaho Department of Health and Welfare. ( )

05. Emergency Medical Services (EMS). The 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. ( )

06. EMS Agency. An organization licensed by the EMS Bureau to provide air medical, ambulance, or non-transport services. ( )

07. EMS Agency Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. ( )

08. EMS Bureau. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. ( )

09. EMS Physicians Commission (EMSPC). The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission." ( )

10. Investigation. Research of the facts concerning a complaint or issue of non-compliance which may include performing or obtaining interviews, inspections, document

review, detailed subject history, phone calls, witness statements, other evidence and collaboration with other jurisdictions of authority. ( )

11. National Registry of Emergency Medical Technicians (NREMT). An independent, non-governmental, not-for-profit organization that prepares validated examinations for the state's use in evaluating candidates for licensure. ( )

12. Personnel License or Certificate Holder. Individuals who possess a valid license or certificate issued by the EMS Bureau. Includes individuals who are Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), Paramedics, and Certified EMS Instructors. ( )

13. Physician. In accordance with Section 54-1803, Idaho Code, a person who holds a current active license issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. ( )

011. -- 074. (RESERVED)

075. PEER REVIEW TEAM.
The EMS Bureau may elect to conduct a peer review for an alleged statute or rule violation when it determines that a peer review is an appropriate action. The EMS Bureau will determine who serves on a peer review team. ( )

076. MEMBERS OF A PEER REVIEW TEAM.
The peer review team will consist of four (4) team members selected by the EMS Bureau as appropriate to the case being considered from the following: ( )

01. Licensed Personnel. EMS personnel licensed at, or above, the license level of the subject; or ( )

02. Agency Administrator. EMS agency administrator; or ( )

03. Training Officer. EMS agency training officer; or ( )

04. Course Coordinator. Course coordinator of an EMS Bureau-approved education program or course; or ( )

05. Instructor. EMS Bureau-certified EMS instructor; and ( )

06. Chairman of Peer Review Team. Each peer review team will be chaired by a licensed Idaho EMS physician as follows: ( )

a. An Idaho EMS Physician Commissioner for cases involving EMS personnel; or ( )

b. An Idaho EMS agency medical director for cases involving an EMS agency; or ( )

c. An Idaho EMS Bureau-approved education program or course sponsoring physician for cases involving educators who are not licensed EMS personnel. ( )

077. QUALIFICATIONS REQUIRED OF A PEER REVIEW TEAM MEMBER.
An individual, serving as a member of an EMS peer review team, must have successfully completed an orientation to EMS-related statute, rules and procedures and have signed confidentiality and conflict of interest agreements provided by the EMS Bureau. ( )

078. -- 099. (RESERVED)

Reporting Of Complaints And Suspected Violations
(Sections 100 -- 199)

100. COMPLAINT SUBMITTED WHEN A VIOLATION IS SUSPECTED.
Complaints must be submitted in writing on a complaint intake form found online at: http://www.idahoems.org. ( )

101. -- 109. (RESERVED)

110. REPORTING SUSPECTED VIOLATION.
Any person who suspects a violation of Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.03, "Emergency Medical Services," may report the violation to the EMS Bureau. ( )

111. ANONYMOUS COMPLAINTS.
Anonymous complaints are accepted; however, the inability to collect further information from the complainant may hinder the progress of the investigation. ( )

112. -- 199. (RESERVED)

Investigation Of Complaints And Suspected Violations
(Sections 200 -- 299)

200. EMS BUREAU INITIATES OFFICIAL INVESTIGATION.
An official investigation will be initiated when the any of the following occurs: ( )

01. Complaint with Allegations. A complaint with an allegation that, if substantiated, would be in violation of Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," or IDAPA 16.02.03, "Emergency Medical Services." ( )

02. Discovery of Potential Violation of Statute or Administrative Rule. EMS

Bureau staff or other authorities discover a potential violation of Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," or IDAPA 16.02.03, "Emergency Medical Services." ( )

201. -- 209. (RESERVED)

210. VIOLATIONS THAT MAY RESULT IN ADMINISTRATIVE ACTIONS.
The EMS Bureau may impose an administrative action, such as denial, revocation, suspension, under conditions that include, but are not limited to, those specified in these rules. Administrative actions may be imposed on any of the following: the holder of a license or certificate, or on an applicant or candidate for an EMS license or certificate. Administrative actions may be imposed on any of the previously mentioned for any action, conduct, or failure to act that is inconsistent with the professionalism, standards, or both, established by statute or rule. ( )

01. Violation of Statute or Administrative Rules. ( )

a. Sections 56-1011 through 56-1023, Idaho Code; ( )

b. IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements;" IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," IDAPA 16.02.03, "Emergency Medical Services," and this chapter of rules. ( )

02. Unprofessional Conduct. Any act that violates professional standards required under IDAPA 16.01.07, "EMS -- Personnel Licensure Requirements." ( )

03. Failure to Maintain Standards of Knowledge, Proficiency, or Both. Failure to maintain standards of knowledge, or proficiency, or both, required under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensure Requirements," and IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ( )

04. Mental Incompetency. A lawful finding of mental incompetency by a court of competent jurisdiction. ( )

05. Impairment of Function. Performance of duties pursuant to an EMS personnel license while under the influence of alcohol, illegal substance, or legal drug or medication causing impairment of function. ( )

06. Denial of Criminal History Clearance. Any conduct, action, or conviction that does or would result in denial of a criminal history clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ( )

07. Discipline, Restriction, Suspension, or Revocation. Discipline, restriction, suspension, or revocation by any other jurisdiction. ( )

08. Danger or Threat to Persons or Property. Any conduct, condition, or

circumstance determined by the EMS Bureau that constitutes a danger or threat to the health, safety, or well-being of persons or property. ( )

09. Performing Medical Procedure or Providing Medication that Exceeds the Scope of Practice of the Level of Licensure. Performing any medical procedure or providing medication that deviates from or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ( )

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

11. Attempting to Obtain a License by Means of Fraud. Misrepresentation in an application, or documentation, for licensure by means of concealment of a material fact. ( )

211. -- 219. (RESERVED)

220. REFUSAL TO PARTICIPATE IN AN INVESTIGATION.
The refusal to participate by the subject will not prohibit full investigation or a peer review, nor prevent potential administrative license action. ( )

221. -- 229. (RESERVED)

230. SURRENDER OR LAPSE OF LICENSE.
Surrender or lapse of a license will not prohibit full investigation with the potential consequence of EMS Bureau imposing a formal administrative license action or fine. ( )

231. -- 239. (RESERVED)

240. INVESTIGATION CONFIDENTIALITY.

01. Informal Resolution. Informal resolution of complaints or non-compliance by guidance or warning letter is considered official correspondence and is public information. ( )

02. Administrative License Action. Preliminary investigations and documents supplied or obtained in connection with them are confidential until a formal notice of administrative license action is issued. ( )

241. -- 249. (RESERVED)

250. NOTICE OF THE FINAL DISPOSITION OF AN INVESTIGATION.

01. Subject. The EMS Bureau will send notification to the last known address of the subject of the disposition of the investigation, including any pending or current administrative actions. ( )

02. Other Jurisdiction for EMS Personnel. A copy of administrative action imposed on EMS personnel will be sent to each agency of affiliation, agency medical director, the National

Practitioners Data Base, and the National Registry of Emergency Medical Technicians. ( )

03. Other Jurisdictions for EMS Agencies. A copy of administrative action or nature of fines imposed on EMS agencies will be sent to the agency governing authorities and the agency medical director. ( )

04. Other Jurisdictions for Educational Programs or Instructors. A copy of any administrative action imposed on an EMS educational program or instructor may be sent to the state Board of Education, the sponsoring physician, the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), and the National Registry of Emergency Medical Technicians (NREMT). ( )

251. -- 299. (RESERVED)

Disciplinary And Corrective Actions (Sections 300 -- 399)

300. PERSONNEL ACTIONS RESULTING FROM INVESTIGATIONS.
The following actions may be imposed upon the subject of an investigation by the EMS Bureau without peer review: ( )

01. Personnel Letter of Guidance. The EMS Bureau may issue a letter of guidance, directing the subject of the investigation to the standards, rules, educational resources, or local jurisdiction for resolution of minor non-compliance issues where no injury or threat of harm to the public, profession, or EMS system occurred. The subject of the investigation must show a willingness to become compliant and correct the issue within thirty (30) days of receipt of the personnel guidance letter. ( )

02. Personnel Warning Letter. The EMS Bureau may issue a warning letter for a first offense where an unlicensed individual is providing patient care in violation of Section 56-1020, Idaho Code; or ( )

03. Negotiated Resolution for Personnel. The EMS Bureau may negotiate a resolution with the subject of an investigation where allegations of misconduct or medical scope of practice non-compliance, if found to be true, did not cause, or is not likely to cause, injury or harm to the public, profession, or EMS system. The issue must be resolved and corrected within thirty (30) days of the negotiated resolution or settlement agreed to by both the subject of the investigation and the EMS Bureau. ( )

a. Negotiated resolution participants will include the subject of the investigation, EMS Bureau staff and other parties deemed appropriate by the EMS Bureau. ( )

b. During the negotiated resolution process, the subject of the investigation may be offered specific remediation or disciplinary action by consent, which, if agreed to, will resolve the matter with no further right to appeal unless stipulated and agreed to at the time that the remediation or disciplinary action is agreed upon. ( )

c. When the remediation or disciplinary action is not agreed to by consent of both the subject of the investigation and the EMS Bureau, the matter may then be referred to a peer review. ( )

301. -- 309. (RESERVED)

310. AGENCY ACTIONS RESULTING FROM INVESTIGATIONS.
The following actions may be imposed upon an EMS agency that is the subject of an investigation by the EMS Bureau without peer review: ( )

01. Agency Letter of Guidance. The EMS Bureau may issue a letter of guidance, directing the EMS agency to the standards, rules, educational resources, or local jurisdiction for resolution of minor non-compliance issues where no injury or threat of harm to the public or EMS system occurred. The EMS agency must show a willingness to become compliant and correct the issue within thirty (30) days of receipt the agency guidance letter. ( )

02. Agency Warning Letter. The EMS Bureau may issue a warning letter for a first offense where an organization is providing unlicensed emergency medical services in violation of Section 56-1021, Idaho Code; ( )

03. Negotiated Resolution for an Agency. The EMS Bureau may negotiate a resolution with the subject of an investigation, where the allegations, if found to be true, did not cause, or is not likely to cause, injury or harm to the public or EMS system. The issue must be resolved within thirty (30) days of the negotiated resolution or a settlement agreed to by both the subject of the investigation and the EMS Bureau. ( )

a. Negotiated resolution participants will include representatives from the EMS agency or the subject under investigation, EMS Bureau staff, and other parties deemed appropriate by the EMS Bureau. ( )

b. During the negotiated resolution process, the subject of the investigation may be offered specific remediation or disciplinary action by consent, which, if agreed to, will resolve the matter with no further right to appeal unless stipulated and agreed to at the time that the remediation or disciplinary action is agreed upon. ( )

c. When remediation or disciplinary action is not agreed to by consent of both the subject of the investigation and the EMS Bureau, the matter may then be referred to a peer review. ( )

310. -- 319. (RESERVED)

320. PEER REVIEW.
The EMS Bureau may elect to conduct a peer review for an alleged statute or rule violations when it determines that a peer review is an appropriate action, or a negotiated resolution or settlement agreement described in Sections 300 and 310 of these rules, is not reached. The peer review is conducted as follows: ( )

01. Review of Case by Peer Review Team. The peer review team reviews the case

details, subject's background, affiliation, licensure history, associated evidence, and documents, and then considers aggravating and mitigating circumstance as follows: ( )

a. Aggravating circumstances can include: prior or multiple offenses, vulnerability of victim, obstruction of the investigation, and dishonesty. ( )

b. Mitigating circumstances can include: absence of prior offenses, absence of dishonest or selfish motive, timely effort to rectify situation, interim successful rehabilitation, misdirection per agency protocol, or medical direction. ( )

02. Subject Given Opportunity to Respond. The subject of the investigation will be given the opportunity to respond in writing, by teleconference, or at the option of the EMS Bureau, in person to the alleged violation. ( )

03. Evaluation of Evidence. The peer review team will evaluate the evidence and make a majority decision of the finding for each alleged statute, rule, or standards violation, including any additional detected violations. ( )

04. Recommend Action. The peer review team will recommend actions to the EMS Bureau. If subject is found to have violated statutes, rules, or standards, the recommendations may include the following: ( )

a. Administrative license action, time frames, conditions, and fines, if imposed, on an EMS agency. ( )

b. Administrative license action, time frames, and conditions, if imposed, on EMS personnel. ( )

321. -- 329. (RESERVED)

330. ADMINISTRATIVE ACTIONS IMPOSED FOR LICENSURE OR CERTIFICATION.
The EMS Bureau may impose the following administrative actions: ( )

01. Deny or Refuse to Renew EMS Personnel License or Certification. The EMS Bureau may deny an EMS personnel license or certification, or refuse to renew an EMS personnel license or certification: ( )

a. When the application for licensure or certification is not complete or the individual does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," IDAPA 16.02.03, "Emergency Medical Services"; or ( )

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well being of persons or property. ( )

c. For any reason that would justify an administrative action according to Section 210 of these rules. ( )

d. Decisions to deny or refuse to renew an EMS license will be reviewed by the Idaho EMS Physicians Commission at the Commission's next available meeting. ( )

02. Deny or Refuse to Renew EMS Agency License. The EMS Bureau may deny an EMS agency license or refuse to renew a EMS agency license: ( )

a. When the application for licensure is not complete or does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.02.03, "Emergency Medical Services"; or ( )

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. ( )

c. For any reason that would justify an administrative action according to Section 210 of these rules. ( )

03. Retain with Probationary Conditions for Personnel License or Certification. The EMS Bureau may allow an EMS personnel license or certificate holder to retain a license or certificate as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. Decisions to retain an EMS personnel license with probationary conditions will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. ( )

04. Retain with Probationary Conditions for Agency License. The EMS Bureau may allow an EMS agency to retain a license as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. ( )

05. Suspend EMS Personnel License or Certificate. The EMS Bureau may suspend an EMS personnel license or certificate for: ( )

a. A period of time up to twelve (12) months, with or without conditions; or ( )

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. ( )

c. Decisions to suspend an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. ( )

06. Revoke EMS Personnel License or Certificate. The EMS Bureau may revoke an EMS personnel license or certificate when: ( )

a. A peer review team recommends license or certificate revocation; or ( )

b. The license holder is found to no longer be eligible for criminal history clearance per IDAPA 16.05.06, "Criminal History and Background Checks." ( )

c. Decisions to revoke an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. ( )

07. Revoke EMS Agency License. The EMS Bureau may revoke an EMS agency license when: ( )

a. A peer review team recommends license revocation; ( )

b. The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which the EMS agency provides emergency prehospital response that the EMS Bureau is considering license revocation. ( )

331. -- 339. (RESERVED)

340. VIOLATIONS THAT MAY RESULT IN FINES BEING IMPOSED ON EMS AGENCY.

In addition to administrative license actions provided in Section 56-1022, Idaho Code, and these rules, a fine may be imposed by the EMS Bureau upon recommendation of a peer review team on a licensed EMS agency as a consequence of agency violations. Fines may be imposed for the following violations: ( )

01. Operating An Unlicensed EMS Agency. Operating without a license required in IDAPA 16.02.03, "Emergency Medical Services," including: ( )

a. Failure to obtain an initial license; ( )

b. Failure to obtain a license upon change in ownership; or ( )

c. Failure to renew a license and continues to operate as an EMS agency. ( )

02. Unlicensed Personnel Providing Patient Care. Allowing an unlicensed individual to provide patient care without first obtaining an EMS personnel license required in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," at the appropriate level for the EMS agency. ( )

03. Failure to Respond. Failure of the EMS agency to respond to a 911 request for service within the agency primary response area in a typical manner of operations when dispatched to a medical illness or injury, under licensure requirements in IDAPA 16.02.03, "Emergency Medical Services," except when the responder reasonably determines that: ( )

a. There are disaster conditions; ( )

b. Scene safety hazards are present or suspected; or ( )

c. Law enforcement assistance is necessary to assure scene safety, but has not yet

allowed entry to the scene. ( )

04. Unauthorized Response by EMS Agency. Responding to a request for service which deviates from or exceeds those authorized by the EMS agency license requirements in IDAPA 16.02.03, "Emergency Medical Services." ( )

05. Failure to Allow Inspections. Failure to allow the EMS Bureau or its representative to inspect the agency facility, equipment, records, and other licensure requirements provided in IDAPA 16.02.03, "Emergency Medical Services." ( )

06. Failure To Correct Unacceptable Conditions. Failure of the EMS agency to correct unacceptable conditions within the time frame provided in a negotiated resolution settlement, or a warning letter issued by the EMS Bureau. Including the following: ( )

a. Failure to maintain an EMS vehicle in a safe and sanitary condition; ( )

b. Failure to have available minimum EMS Equipment; ( )

c. Failure to correct patient or personnel safety hazards; or ( )

d. Failure to retain an EMS agency medical director: ( )

07. Failure to Report Patient Care Data. Failure to submit patient care data as required in IDAPA 16.02.03, "Emergency Medical Services." ( )

341. FINES IMPOSED ON EMS AGENCY.

In addition to administrative license action allowed by statute and rule, a fine may be imposed by the EMS Bureau upon the recommendation of a peer review team. Fines are imposed on licensed EMS agency as a consequence of agency licensure violations. ( )

01. Maximum Amount of a Fine. A fine may not exceed one thousand dollars ($1000) for each specified violation. ( )

02. Fines Levied After Peer Review. The EMS Bureau may levy a fine against an EMS agency following a peer review that has a majority decision on finding and outcomes, and includes a fine be imposed as part of the recommended action. ( )

03. Table for Maximum Fine Amount. The maximum amount of a fine that may be imposed on an EMS agency for certain violations listed in Section 330 of these rules are provided in the table below:

EMS AGENCY FINE AMOUNT FOR VIOLATIONS Section 341.03		
Rule Violation Subsection	**TYPE OF VIOLATION**	**Maximum Fine (each violation)**
340.01.	**Operating an Unlicensed EMS Agency.** **a.** Failure to obtain an initial license: **b.** Failure to obtain a license upon change of ownership: **c.** Failure to successfully renew a license:	 $1000 $ 500 $ 500
340.02.	**Unlicensed EMS Personnel Providing Patient Care.**	$ 500
340.03.	**Failure to Respond.**	$ 750
340.04.	**Unauthorized Response by EMS Agency.** Licensed EMS agency responds to a request for service which deviates from or exceeds those authorized by the EMS agency license.	$ 500
340.05.	**Failure to Allow an Inspection of an EMS Agency.**	$ 500
340.06.	**Failure to Correct Unacceptable Conditions.** **a.** Failure to maintain an EMS vehicle in a safe and sanitary condition: **b.** Failure to have available minimum EMS equipment: **c.** Failure to correct patient or personnel safety hazards: **d.** Failure to retain an EMS agency medical director:	 $ 250 $ 250 $ 250 $ 500
340.07.	**Failure to Report Patient Care Data.**	$ 500

( )

342. COLLECTED FINES.

Money collected from EMS agency fines will be deposited into the Emergency Medical Services Fund III provided for in Section 56-1018B, Idaho Code, a dedicated fund account for the purpose of providing grants to acquire vehicles and equipment for use by emergency medical services personnel in the performance of their duties. ( )

343. -- 349. (RESERVED)

350. REINSTATEMENT OF EMS LICENSE FOLLOWING REVOCATION.

An application of any revoked EMS agency or personnel license may be filed with the EMS Bureau no earlier than one (1) year from the date of the license revocation. ( )

01. Peer Review for Reinstatement. The EMS Bureau will conduct a peer review to consider the reinstatement application. ( )

02. Recommendation of Peer Review Team. The peer review team will make a recommendation to the EMS Bureau to accept or reject the application for reinstatement. ( )

03. Reinstatement Determination. The EMS Bureau will accept or reject the reinstatement application based on the peer review team recommendation and other extenuating circumstances. ( )

a. Reinstatement of a revoked EMS personnel license is subject to the lapsed license reinstatement requirements in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

b. Reinstatement of a revoked EMS agency license will be subject to an initial agency application requirements in IDAPA 16.02.03, "Emergency Medical Services." ( )

351. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.02 - RULES OF THE EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 35 and 36.

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

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

DATED this 1st day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

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

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

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered during 2010.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2012-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written

comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 28th day of June, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1101

004. INCORPORATION BY REFERENCE.

The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~1~~2-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the internet or from the EMS Bureau located at 650 W. State Street, Suite B-17, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036.

~~*(4-7-11)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.03 - EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0203-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

The Department updated the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department reorganized the EMS rules. The Department has a new chapter of rule, IDAPA 16.01.01, "Emergency Medical Services (EMS) - Advisory Committee (EMSAC)," that takes effect Sine Die 2012. The changes to the proposed text in this docket removes those items that have been placed into this new chapter of rule adopted as pending under Docket 16-0101-1101, in this same Bulletin.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the July 6, 2011, Idaho Administrative Bulletin, Vol. 11-7, pages 87 through 112**.**

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. The Emergency Medical Services (EMS) program is funded through dedicated funds.

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

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of this temporary rule is **July 1, 2011**.

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

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

Tuesday, August 2, 2011 at 6:00 p.m. (Local)	
Central Fire District **697 Annis Hwy.** **Rigby, ID**	**Kamiah Emergency Services** **515 Main Street** **Kamiah, ID**

Wednesday, August 3, 2011 at 6:00 p.m. (Local)	
Caribou County Fire Station **665 E. 2nd S.** **Soda Springs, ID**	**New Meadows Fire Station** **200 Hwy. 95** **New Meadows, ID**

Thursday, August 4, 2011 at 6:00 p.m. (Local)	
Jerome City Fire/Rescue **110 W. Yakima Ave.** **Jerome, ID**	**EMS Bureau Conf. Rm. B25** **LBJ Office Bldg. 650 W. State St.** **Boise, ID**

Friday, August 5, 2011 **at 6 p.m. (Local)**	**Saturday, August 6, 2011** **at 6 p.m. (Local)**

Bonner County EMS **521 3rd Ave.** **Sandpoint, ID**	**Moscow Fire Station #3** **229 Pintail Ln.** **Moscow, ID**

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

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

The Department is updating the Emergency Medical Services rules and the Idaho EMS system to reflect current national standards for safety and quality of services. Through the process of implementing new rules, the Department is reorganizing the EMS rules. The current chapter of rules is being updated as follows:

1. **Removes EMS personnel licensure standards, requirements, scope of practice, application, fees, and records management;**
2. **Amends the scope of practice including definitions and terminology needed to meet agency requirements and rules that stay in this chapter;**
3. **Removes investigation, enforcement and compliance requirements for agency and personnel licensing;**
4. **Adds references to new chapters for personnel licensure, complaints, investigations, compliance, and enforcement of all EMS rules; and**
5. **Amends sections to meet statutory requirements, standards, terminology from previous rulemaking under Docket 16-0203-0901 that is being rescinded and vacated in this bulletin.**

Other dockets publishing in this bulletin that implement the reorganization of EMS services are: 16-0107-1101, 16-0107-1102, 16-0112-1101, and 16-0101-1101.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of these rules are appropriate in order to protect the public health, safety or welfare.

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

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

This rulemaking has no fiscal impact to the state general fund. The Emergency Medical Services (EMS) program is funded through dedicated funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was conducted over server al years. The negotiated rulemaking for these rules

published in the March 2, 2011, Idaho Administrative Bulletin, Vol. 11-3, page 14, **under the current rule, IDAPA 16.02.03, "Emergency Medical Services," Docket No. 16-0203-1101.**

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 Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 12, 2011.

DATED this 3rd day of June, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0203-1101

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, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. ~~(4-6-05)~~( )

001. TITLE AND SCOPE.

0~~2~~1. 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)~~( )

0~~1~~2. Scope. These rules include criteria for ~~*training*~~ education programs, certification of ~~*personnel*~~ instructors, licensure of ambulance services and nontransport services including required agency personnel, licensure of ambulances and nontransport vehicles, establishment of fees for training, inspections, and certifications~~, and appropriate requirements for recertification of personnel~~. ~~(7-1-97)~~( )

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)~~( )

003. ADMINISTRATIVE APPEALS.
~~All~~ Administrative appeals and 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)~~( )

004. INCORPORATION BY REFERENCE.
The Board of Health and Welfare has adopted the Minimum Equipment Standards for Licensed EMS Services, 20~~04~~11 edition, Version ~~4~~1.0, as its standard on required EMS equipment and hereby incorporates the Equipment Standards by reference. Copies of the Equipment Standards 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. ~~(4-6-05)~~( )

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. ( )

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)

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

04. Telephone. ( )

a. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500.(4-6-05)

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

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. -- 009. (RESERVED)

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.*~~ A person who has met the qualifications for AEMT licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements." ~~*(4-6-05)*~~( )

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*~~ by the EMS Bureau. ~~*(4-5-00)*~~( )

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 required to be licensed by the EMS Bureau that operates an air medical service, ambulance service, or nontransport service. ~~*(4-5-00)*~~( )

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. ( )

0~~5~~6. 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)*~~( )

07. Air Medical Service. An agency required to be 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. ( )

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)~~( )

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 required to be 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. ( )

11. **Applicant**. Any organization that is requesting an agency license under these rules and includes the following: ( )

a. An organization seeking a new license; ( )

b. An existing agency that intends to change the level of licensed personnel it utilizes; ( )

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

d. An existing nontransport service that intends to provide ambulance service; and ( )

e. An existing ambulance service that intends to discontinue transport and become a nontransport service. ( )

~~**08**~~**12.** **Board**. The Idaho ~~*State*~~ Board of Health and Welfare. ~~(12-31-91)~~( )

~~**09**~~**13.** **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. ~~(7-1-97)~~( )

~~***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, "Rules for EMS Personnel*~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physicians Commission." ~~(4-6-05)~~( )

15. **Commission**. The Idaho Emergency Medical Services Physician Commission

(EMSPC). ( )

16. **Department**. The Idaho Department of Health and Welfare. ( )

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

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

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 has met the qualifications for EMR licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements." ( )

~~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)~~( )

22. **Emergency Medical Technician (EMT)**. A person who has met the qualifications for EMT licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements." ( )

2~~2~~3. **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)

~~16~~24. **EMS Bureau**. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (11-19-76)

~~17~~25. **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)~~

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)~~( )

29. **Licensed Personnel**. Individuals licensed by the EMS Bureau who are Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. ( )

~~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. ( )

~~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)~~( )

~~**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 required to be 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. ( )

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. ( )

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 has met the qualifications for paramedic licensure defined in Section 56-1012, Idaho Code, and in IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements." ( )

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)~~( )

38. **Patient Care**. The performance of acts or procedures under emergency conditions 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. ( )

3~~2~~9. **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)~~( )

~~33~~40. **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)~~( )

~~3~~41. **State Health Officer**. The Administrator of the Division of Public Health. ~~(11-19-76)~~( )

42. **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: ( )

a. Establishing standing orders and protocols; ( )

b. Reviewing performance of licensed personnel; ( )

c. Providing instructions for patient care via radio or telephone; and ( )

d. Other oversight. ( )

~~35~~43. **Transfer**. The transportation of a patient from one (1) medical care facility to another ~~by ambulance~~. ~~(4-5-00)~~( )

011. -- 0~~99~~74. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS LICENSING VIOLATIONS.
Investigation of complaints and disciplinary actions for EMS agency licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

076. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.
Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions, including fines, imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

~~***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)~~

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

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

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

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

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

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

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

~~i. One (1) representative of a volunteer third service EMS/Ambulance organization; and (4-8-94)~~

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

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

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

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

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

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

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

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

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

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

~~t. One (1) consumer; and (4-5-00)~~

~~u. One (1) representative of a private EMS transport organization; and (4-5-00)~~

~~v. 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. 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; (11-19-76)~~

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

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

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

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

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

~~*101*~~*077*. -- 199.(RESERVED)

200. EMS ~~*TRAINING*~~ EDUCATION PROGRAMS.
EMS ~~*training*~~ education 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*~~ Education Program may be approved by the EMS Bureau only if all requirements are met. The EMS ~~*Training*~~ education Program must be approved in order for candidates to qualify for access to a certification examination. ~~(7-1-97)~~( )

201. STANDARDS.
All initial ~~*training*~~ education programs must be conducted ~~*in accordance*~~ using with the following criteria: ~~(4-6-05)~~( )

01. Course Coordinator. Each EMS ~~*training*~~ education 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)~~( )

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*~~ education 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~~ education courses must be conducted under the direction of a physician. ~~(4-6-05)~~( )

04. Curriculum and Equipment. ~~Training~~ Education 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)~~( )

203. MONITORING OF INSTRUCTOR PERFORMANCE.
The EMS Bureau ~~shall~~ will monitor instructor performance for all EMS ~~training~~ education 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~~ education programs. ~~(7-1-97)~~( )

(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)~~( )

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~~ education program content and EMS ~~certification~~ licensure levels. ~~(4-6-05)~~( )

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)~~( )

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)~~( )

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)*~~( )

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*~~ instruction of the course, and instruct or oversee the skills training in the curriculum. ~~*(4-6-05)*~~( )

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)*~~( )

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)*~~( )

~~***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)~~( )

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)~~( )

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)~~( )

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)*~~( )

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)*~~( )

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)~~( )

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)~~( )

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)~~( )

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)~~( )

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)*~~( )

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)*~~( )

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)*~~( )

04. Records to Be Maintained. The nontransport service must maintain records of each EMS response in a form approved by the EMS Bureau. ~~*that*~~ 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)*~~( )

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

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

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

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

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

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

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

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

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

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

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

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)~~( )

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)~~( )

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*~~ Agencies which ~~*function*~~ provide licensed personnel at or above the paramedic level will be designated as Advanced Life Support services ~~*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)*~~( )

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 for ALS under IDAPA ~~22.01.06, "Rules for EMS Personnel," Subsection 011.05,~~ 16.02.02, "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)~~( )

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)~~( )

a. ~~EMT~~ Paramedic personnel must hold a current ~~certification~~ paramedic license issued by the EMS Bureau ~~in accordance with Sections 501 and 510 of these rules~~ under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements."
~~(4-5-00)~~( )

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~~ education 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)~~( )

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, "Rules for EMS Personnel," Subsection 011.05.~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~(4-6-05)~~( )

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)~~( )

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)~~( )

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)~~( )

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~~ under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." The agency is specifically prohibited from advertising as or responding to requests for critical care transfer service unless the agency also holds a Critical Care Transfer Service designation ~~in accordance with~~ under Section 335 of these rules. ~~(4-5-00)~~( )

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 for ALS under IDAPA ~~22.01.06, "Rules for EMS Personnel," Subsection~~

~~011.05,~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," 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)~~( )

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~~ paramedic license issued by the EMS Bureau ~~in accordance with Sections 501 and 510 of these rules~~ under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ~~(4-5-00)~~( )

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~~ education 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)~~( )

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, "Rules for EMS Personnel," Subsection 011.05~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~(4-5-00)~~( )

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)~~( )

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)~~( )

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)~~( )

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*~~ under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." The agency is specifically prohibited from advertising or responding to pre-hospital and emergency requests for ALS unless the agency also holds a 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 a Critical Care Transfer (CCT) Service designation in accordance with Section 335 of these rules. ~~*(4-5-00)*~~( )

331. -- 334. (RESERVED)

335. CRITICAL CARE TRANSFER (CCT) SERVICE STANDARDS.
Critical Care Transfer (CCT) 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*~~ will 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 (CCT) Service designation if the following criteria are met:
~~*(4-5-00)*~~( )

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*~~ paramedic license issued by the EMS Bureau ~~*in accordance with Sections 501 and 510 of these rules*~~ under IDAPA 16.01.07, "Emergency Medical Services (EMS) - Personnel Licensing Requirements." ~~*All EMT-*~~ Paramedics who will be the primary or the only care provider during critical care transfers must have successfully completed a formal ~~*training*~~ education program in critical care transport which meets or exceeds the objectives of the curriculum approved by the State Health Officer.
~~*(4-5-00)*~~( )

b. An agency which will advertise or provide ~~*ALS*~~ CCT 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*~~ education 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)*~~( )

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, "Rules for EMS Personnel," Subsection 011.05*~~ 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission."
~~*(4-5-00)*~~( )

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)*~~( )

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)*~~( )

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)*~~( )

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*~~ under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." 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*~~ under Section 325 of these rules. ~~*(4-5-00)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

400. ADVANCE DO NOT RESUSCITATE (DNR) 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)*~~( )

02. Do Not Resuscitate (DNR) 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 (DNR) 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~~ Education 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~~ these rules into initial training curricula and required continuing education of ~~certified~~ licensed EMS personnel. ~~(4-11-06)~~( )

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)~~( )

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)~~( )

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)~~( )

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)~~( )

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)~~( )

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)*~~( )

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)*~~( )

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*~~ this rule~~s~~ by June 30, 2007. ~~*(4-11-06)*~~( )

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*~~ this rule~~s~~ as a component of required continuing education for ~~*recertification*~~ license renewal not later than ~~*June*~~ September 30, 2010. ~~*(4-11-06)*~~( )

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)*~~( )

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)

436. -- ~~4~~99. (RESERVED)

~~***500. CERTIFICATION.***~~
~~*In order to practice or represent himself as a First Responder, EMT-B, AEMT-A, EMT-I, or EMT-P, an individual must maintain current certification issued by the EMS Bureau.* *(4-6-05)*~~

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

~~***01. Affiliation Required**. Candidates for certification at the 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 being sought by the applicant;* *(4-6-05)*~~

~~***02. Required Identification**. Candidates for certification 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)*~~

~~***03. Criminal Background Check**. A criminal background check must be conducted*~~

for all applicants for initial certification 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, 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. *(4-6-05)*

***04. Fee for Initial Certification**. The fee for initial certification for AEMT-A, EMT-I, and EMT-P is thirty-five dollars ($35).* *(4-6-05)*

***05. Required Examination**. Candidates for certification 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 being sought in accordance with the EMS Standards Manual in effect at the time of application.* *(4-6-05)*

502. -- 509. (RESERVED)

510. CERTIFICATION DURATION AND RECERTIFICATION.
All certification 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. *(4-6-05)*

***01. First Responder Certification**. A First Responder will be issued certification for three (3) years. The duration of initial certification may be up to forty-two (42) months from the date of examination. Continuing education and refresher course must be conducted in accordance with the EMS Standards Manual in effect at the beginning of the certification interval.* *(4-6-05)*

***02. EMT-B Certification**. An EMT-B will be issued certification for three (3) years. The duration of initial certification 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 interval.* *(4-6-05)*

***03. AEMT-A Certification**. An AEMT-A 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)*

***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)*

***05. EMT-P Certification**. An EMT-P 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 courses, and proficiency assurance documentation will 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)~~

~~**06. Required Documentation**. Documentation of recertification requirements is due to the EMS Bureau prior to the certification expiration date. Failure to submit complete documentation of requirements by the certification expiration date renders the certification invalid and the candidate must not practice or represent himself as certified personnel.~~ ~~(4-6-05)~~

~~**07. Affiliation Required**. Candidates for recertification at the EMT-B, AEMT-A, EMT-I, and EMT-P levels must have current affiliation with a licensed EMS service.~~ ~~(4-6-05)~~

~~511. LAPSED CERTIFICATION.~~

~~After the expiration date of certification issued by the EMS Bureau, the certification will no longer be valid unless required recertification documentation has been submitted. No grace periods or extensions to an expiration date may be granted.~~ ~~(4-6-05)~~

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

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

~~512. SURRENDER OF CERTIFICATION.~~

~~An individual who possesses current certification may relinquish that certification 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)~~

~~513. REVERSION.~~

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

~~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 if the individual satisfies the criteria for initial certification and has current NREMT registration or state EMS certification at or above the level of certification being sought.~~ ~~(7-1-97)~~

~~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 established by these rules including, but~~

not limited to the following: (7-1-97)

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

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

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 established under IDAPA 22.01.06, "Rules for EMS Personnel." (7-1-97)

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 issued pursuant to these rules may report the violation to the EMS Bureau. (7-1-97)

601. PRELIMINARY INVESTIGATION.
The EMS Bureau shall make a preliminary investigation of all the facts and circumstances surrounding the reported facts and events and shall make a report of such facts to the Emergency

~~*Medical Services Advisory Committee Disciplinary Subcommittee 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)~~

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

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

~~***604. 999. (RESERVED)***~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1102

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

House Bill 260, passed by the 2011 Legislature, repealed, amended, and added statutes that are being referenced in these rules. Changes in effect regarding hospital floor reimbursement percentage and the reduction to outpatient hospital costs were continued under this rulemaking. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 50 through 55.

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

The state general fund savings associated with this rulemaking are estimated to be $388,000 for the state fiscal year 2012 and was included in the Department's appropriations for SFY 2012.

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

DATED this 7th day of October, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511, and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

The Department is continuing rule changes published as temporary rules under Docket No. 16-0309-1004, in the September 1, 2010, Idaho Administrative Bulletin, Vol. 10-9, **regarding changes in the definition for hospital floor reimbursement percentage and the reduction to outpatient hospital costs. House Bill 260, adopted by the 2011 Legislature, repealed, amended, and added statutes that are being referenced and updated in the Legal Authority section of these rules.**

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

These rule changes implement statutory changes adopted by the 2011 Legislature and continue statutory changes made regarding hospital reimbursement.

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

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

The state general fund savings associated with this rulemaking are estimated to be $388,000 for the state fiscal year 2012 and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

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

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 8th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1102

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, and 56-1610, Idaho Code. ~~*(3-30-07)*~~( )

02. General Administrative Authority. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-30-07)

03. Administration of the Medical Assistance Program. (3-30-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-30-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-30-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code,

establish minimum standards that enable these rules. ~~(3-30-07)~~( )

04. Fiscal Administration. (3-30-07)

a. Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-30-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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. Critical Access Hospitals (CAH). A rural hospital with twenty five (25) or less beds as set forth in 42 CFR Section 485.620. (4-7-11)

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

10. 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. ( )

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)~~( )

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

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

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

11. 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)

12. 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)

13. 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)

14. 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)

15. 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)

16. 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)

17. 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)

18. 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 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. (4-7-11)

19. 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)

20. 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)

21. 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)

22. 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)

23. 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. (4-7-11)

c. For inpatient services on or after July 1, 2010, the principal year will be the Medicare cost report period used to prepare the Medicaid cost settlement. (4-7-11)

24. 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)

25. 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)

26. 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)*~~( )

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

b. The floor calculation for in-state CAH hospitals is one hundred one percent

(101%) of Medicaid costs. ( )

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. ( )

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. ( )

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

28. 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. (4-7-11)

29. 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)*~~( )

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. ( )

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1103

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

House Bill 260, passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid-eligible participants' dental services. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 56 through 62.

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

These rule changes are estimated to result in cost savings of $2,101,600 ($632,900 state funds, and $1,468,700 federal funds) for state fiscal year 2012.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 7th day of October, 2011.

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 NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is **July 1, 2011**.

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

House Bill 260 passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid eligible participants' dental services. Section 56-255(5)(c), Idaho Code, provides children access to prevention, diagnosis and treatment services defined in federal law. Adult coverage is limited to medically necessary services with the exception that pregnant women have access to dental services that reflect evidence-based practice. This rulemaking reflects changes needed to meet statutory requirements.

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 for the following reasons:

These rule changes implement statutory changes adopted by the 2011 Legislature effective July 1, 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:

These rule changes are estimated to result in cost savings of $2,101,600 ($632,900 state

funds, and $1,468,700 federal funds) for state fiscal year 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

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 August 24, 2011.

DATED this 7th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1103

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0309-1103

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Podiatrist services are described in Sections 540 through 546. (3-30-07)

d. Optometrist services are described in Sections 550 through 556. (3-30-07)

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 569 of these rules**.** (5-8-09)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. (5-8-09)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

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

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

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

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

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

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

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

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

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

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

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

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

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

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

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

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

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

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

16. Vision Services. Vision services are described in Sections 780 through 789 of

these rules.(5-8-09)

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules.
~~(5-8-09)~~( )

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

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

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

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

d. School-Based services are described in Sections 850 through 856. (3-30-07)

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

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

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

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

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

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: DENTAL SERVICES
(Sections 800 -- 819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE ~~UNDER THE BASIC PLAN~~.
All participants who are eligible for Medicaid's Basic Plan dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles. ( )

~~**01. Dental Coverage Under the Selective Contract**. Children and adults under the Medicaid Basic Plan, including pregnant women in the Low Income Pregnant Women coverage~~

~~*group, are covered under a selective contract with Blue Cross of Idaho for preventative dental visits, treatments, and restorative services. For more details on covered dental services go to http://www.bcidaho.com/about_us/idaho_smiles.asp.* (5-8-09)~~

~~***02. 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.* (5-8-09)~~

801. DENTAL SERVICES: DEFINITIONS.
For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions apply: ( )

01. Adult. A person who is past the month of his twenty-first birthday. ( )

02. Child. A person from birth through the month of his twenty-first birthday. ( )

03. Idaho Smiles. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. ( )

04. Medicare/Medicaid Coordinated Plan (MMCP). Medical assistance in which Medicaid purchases services from a Medicare Advantage Organization (MAO) and provides other Medicaid-only services covered under the Medicaid Basic Plan in accordance with IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Basic Plan are eligible for Idaho Smiles dental benefits described in Section 803 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/ Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles. ( )

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may require authorization from the Idaho Smiles contractor. ( )

01. Dental Coverage for Children. Children are covered for dental services that include: ( )

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery; ( )

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. ( )

02. Children's Orthodontics Limitations. Orthodontics are limited to children who meet the Basic Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. ( )

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 803.03 - ADULT DENTAL SERVICES CODES

Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abcess
D7511	Incision and drainage of abcess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation

TABLE 803.03 - ADULT DENTAL SERVICES CODES	
Dental Code	Description
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

( )

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem-focused exams, diagnostic, restorative, endontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at dental services. ( )

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. ( )

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. ( )

01. Administer Idaho Smiles. The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. ( )

02. Authorization. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. ( )

03. Complaints and Appeals. Complaints and appeals are handled through a process between Idaho Smiles and the Department that is in compliance with state and federal requirements. ( )

805. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ( )

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. ( )

807. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. ( )

80~~1~~8. -- 819. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1104

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is **July 1, 2011**. This pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

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

Rule changes are being made to continue cost saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

Based on comments received during the public comment period, amendments are being made in the temporary and pending rule to more clearly differentiate how vision services benefits apply to participants over and under age twenty-one.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 63 through 87.

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

The estimated cost savings for these rule changes are as follows: $347,000 to continue cost saving measures begun in SFY 2011; in addition, under HB 260: $200,000 - chiropractic, $70,000 - audiology, and $800,000 - podiatry and vision.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is: $1,417,000 and was included in the Department's appropriations for SFY 2012.

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

DATED this 1st day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

Rule changes are needed to continue cost saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

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

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

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

The estimated cost savings for these rule changes are as follows: $347,000 to continue cost saving measures begun in SFY 2011. In addition, under HB 260: $200,000 - chiropractic; $70,000 - audiology; and $800,000 - podiatry and vision.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is: $1,417,000 and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

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 Paul Leary at (208) 364-1836.

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 August 24, 2011.

DATED this 8th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1104

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)

532. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. The Department will pay for a total of ~~*twenty-four*~~ six (~~24~~6) manipulation visits during any calendar year for remedial care by a chiropractor ~~*but only for treatment involving manipulation of the spine to correct a subluxation condition*~~. ~~*(3-30-07)*~~( )

533. (RESERVED)

534. CHIROPRACTIC SERVICES: PROVIDER QUALIFICATIONS.
A person who is qualified to provide chiropractic services is licensed by the Board of Chiropractic Physicians in the Idaho Board of Occupational Licensing, or is licensed according to the regulations in the state where the services are provided. ( )

53~~3~~5. -- 539. (RESERVED)

540. PODIATRIST SERVICES: DEFINITIONS.
~~*The Department will reimburse podiatrists for treatment of acute foot conditions.*~~ ~~*(3-30-07)*~~

01. Acute Foot Conditions. An ~~*A*~~acute foot condition~~*s*~~, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. ~~*Preventive foot care may be provided if vascular restrictions or other systemic disease is threatened.*~~ ~~*(3-30-07)*~~( )

02. Chronic Foot Diseases. Chronic foot diseases, for the purpose of this provision, include: ( )

a. Diabetes melitus; ( )

b. Peripheral neuropathy involving the feet; ( )

c. Chronic thrombophlebitis; and ( )

d. Peripheral vascular disease; ( )

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or ( )

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. ( )

541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are: ( )

01. Participants Who Have a Chronic Disease. Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care. ( )

02. Participants with an Acute Condition. Participants with an acute condition that, if left untreated, may cause an adverse outcome to the participant's health. ( )

542. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to: ( )

01. Services Defined in Chronic Care Guidelines. Acute and preventive foot care services defined in chronic care guidelines; and ( )

02. Treatment of Acute Conditions. Treatment of acute conditions that if left untreated will result in chronic damage to the participant's foot. ( )

543. (RESERVED)

544. PODIATRIST SERVICES: PROVIDER QUALIFICATIONS.
A qualified podiatrist is licensed by the Board of Podiatry in the Idaho Board of Occupational Licensing, or licensed according to the regulations in the state where the services are provided. ( )

54~~1~~5. -- 553. (RESERVED).

(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~~.~~; *and* ~~*(4-2-08)*~~( )

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

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)*~~( )

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)*~~( )

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; ( )

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 ( )

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. ( )

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

1134, 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)( )

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.*~~ **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.

~~(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)~~

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. ( )

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)~~( )

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)~~( )

~~***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)*( )

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)*( )

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

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

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

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

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

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

fd. 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)***( )

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*~~. Psychological and neuropsychological testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. ~~(5-8-09)~~( )

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)*~~( )

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)*~~( )

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*~~ revision of the individualized treatment plan must be recorded on the treatment plan. ~~*(5-8-09)*~~( )

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: ( )

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. ( )

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. ( )

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. ( )

(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)~~( )

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)~~( )

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)

741. AUDIOLOGY SERVICES: PARTICIPANT ELIGIBILITY.
~~*When specifically ordered by a physician, all participants are eligible for audiometric*~~

~~examination and testing once in each calendar year.~~ ~~(3-30-07)~~

01. All Participants. All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. ( )

02. Participants Under the Age of 21. Participants under the age of twenty-one (21) are eligible for all services listed in Section 742 of these rules. ( )

742. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
All audiology services must be ordered by a physician or midlevel practitioner. The Department will pay for routine audiometric examination and testing once in each calendar year, and audiometric services and supplies in accordance with the following guidelines and limitations:
~~(3-30-07)~~( )

01. Non-Implantable Hearing Aids. When there is a documented hearing loss of at least thirty (30) decibels based on the standard Pure Tone Average (500, 1000, 2000 hertz), the Department will cover the purchase of ~~one (1)~~ non-implantable hearing aids ~~per~~ for participants ~~per lifetime~~ under the age of twenty-one (21) with the following requirements and limitations:
~~(4-2-08)~~( )

a. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (3-30-07)

b. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21): batteries purchased on a monthly basis, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting. ~~(3-30-07)~~( )

c. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended. (3-30-07)

02. Implantable Hearing Aids. The Department may cover a surgically implantable hearing aid for participants under the age of twenty-one (21) when: ~~(4-2-08)~~( )

a. There is a documented hearing loss as described in Subsection 742.01 of this rule; (4-2-08)

b. Non-implantable options have been tried, but have not been successful; and (4-2-08)

c. The Department has determined that a surgically implanted hearing aid is medically necessary through the prior authorization process. The Department will consider the guidelines of private and public pay~~o~~ers, evidence-based national standards or medical practice,

and the medical necessity of each participant's case. ~~(4-2-08)~~( )

03. Provider Documentation Requirements. The following information must be documented and kept on file by the provider: (4-2-08)

a. The participant's diagnosis; (4-2-08)

b. The results of the basic comprehensive audiometric exam which includes pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and (4-2-08)

c. The brand name and model type of the hearing aid needed. (4-2-08)

04. Allowance to Waive Impedance Test. The Department will allow a medical doctor to waive the impedance test based on his documented judgment. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

781. VISION SERVICES: PARTICIPANT ELIGIBILITY.
~~*Replacement of broken, lost, or missing glasses is the responsibility of the participant.* (3-30-07)~~

01. Children Under the Age of 21. Children under the age of twenty-one (21) are eligible for all services listed in Section 782 of these rules. ( )

02. Adults Age 21 and Over. Adults age twenty-one (21) and over are eligible for: ( )

a. Services necessary to treat or monitor a chronic condition, such as diabetes, that may damage the eye; and ( )

b. Acute conditions that if left untreated may cause permanent or chronic damage to the eye. ( )

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. ( )

a. *For participants under the age of twenty-one (21):* ( )

i. 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. ( )

ii. ~~Each eligible Medicaid participant,~~ The Department will pay for eyeglasses within Department guidelines 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)~~( )*

~~b.~~ *For participants age twenty-one (21) and older, the Department will pay participating physicians and optometrists for medically necessary eye examinations when the participant has a chronic condition that may damage the eye, or when there is an acute condition that, if left untreated, may cause permanent or chronic damage to the eye.* *( )*

02. Lenses. *For participants under the age of twenty-one (21), ~~L~~l*enses, 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. *For participants age twenty-one (21) and over, one (1) pair of eyeglasses is covered following cataract surgery or when necessary to prevent permanent damage to the eye.* *~~(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 *for participants under the age of twenty-one (21)* only with documentation *~~that an extreme condition requiring a~~* of: *( )*

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

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)~~( )*

~~d.~~ *For participants age twenty-one (21) and over, contact lenses will be covered only when necessary to treat a chronic condition, such as keratoconus, that progressively degrades vision.* *( )*

03. Replacement Lenses. Replacement lenses will be purchased *for participants under the age of twenty-one (21)* 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.

Replacement lenses for participants age twenty-one and older will be purchased when necessary to prevent permanent damage to the eye. ~~(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 *for eligible participants under the age of twenty-one (21)* not more often than once every four (4) years ~~for eligible participants~~; ~~(3-30-07)~~( )

b. ~~Except w~~*W*hen it is documented by the ~~physician~~ *vision provider* 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)~~( )

c. *Frames will be purchased for participants age twenty-one (21) and older when necessary to prevent permanent damage to the eye.* ( )

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. ( )

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. ( )

a. Non-covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. ( )

b. Replacement of broken, lost, or missing glasses is the responsibility of the participant. ~~(3-30-07)~~( )

c. *Examinations for routine vision correction related to nearsightedness, farsightedness, or astigmatism are not covered for participants age twenty-one (21) and older.* ( )

(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)

~~e~~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 o~~r~~f 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

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1106

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of this temporary rule is **January 1, 2012**. The pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary. The action is authorized pursuant to Sections 56-202(b), and 56-209p, Idaho Code.

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

Under Section 56-209p, Idaho Code, the Department is required to pay for midwife services provided to eligible participants through the medical assistance program. Because system changes are needed to add this provider group for Licensed Midwife (LM) Services and time is needed to enroll providers, these rules are being adopted as temporary rules effective January 1, 2012. Changes to the proposed rule docket have been made based on comments received and provide for the administration and policies needed to reimburse for LM services.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice and includes changes made to the pending rule. The text of the pending rule has been modified in accordance with Section 67-5227, Idaho Code. The original text of the proposed rule was published in the October 5, 2011, Idaho Administrative Bulletin, Vol. 11-10, pages 379 through 385**.**

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

These changes are needed to meet statutory requirements that were adopted by the 2011 Legislature under House Bill 165.

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 anticipated fiscal impact due to this rulemaking is uncertain given the uncertainty of the number of participants who will choose to use Licensed Midwife (LM) services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 165.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rule, contact Jeanne Siroky (208) 364-1897.

DATED this 18th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), and 56-209p, Idaho Code.

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

Tuesday, October 20, 2011
6:00 p.m. (Local)

Health & Welfare Region VI
1720 Westgate Drive
Suite A Rm. 131
Boise, ID

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

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

Under Section 56-209p, Idaho Code, the Department is required to pay for midwife services provided to eligible participants through the medical assistance program. Because system changes are needed to add this provider group for Certified Professional Midwife (CPM) Services and time is needed to enroll providers, these proposed rules will be implemented on January 1, 2012. The changes in this docket provide for the administration and policies needed to reimburse for CPM services.

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

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

The anticipated fiscal impact due to this rulemaking is uncertain given the uncertainty of the number of participants who will choose to use Certified Professional Midwife (CPM) services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 165.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Siroky (208) 364-1897.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 8th day of September, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1106

011. DEFINITIONS: I THROUGH O.

For the purposes of these rules, the following terms are used as defined below: (3-30-07)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. Midwife. An individual qualified as one of the following: ( )

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

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

16~~7~~7. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

17~~8~~8. Nonambulatory. Unable to walk without assistance. (3-30-07)

1~~8~~9. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

~~***19. Nurse Midwife (NM)**. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."* (3-30-07)~~

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Podiatrist services are described in Sections 540 through 54~~6~~5. ~~(3-30-07)~~( )

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

~~d~~e. Optometrist services are described in Sections 55~~0~~3 through 556. ~~(3-30-07)~~( )

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 569 of these rules**.** (5-8-09)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. (5-8-09)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

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

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

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

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

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

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

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

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

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

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

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

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

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

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

15. Durable Medical Equipment and Supplies. The range of covered durable

medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

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

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

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

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

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (7-1-11)T

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

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

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

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

d. School-Based services are described in Sections 850 through 856. (3-30-07)

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

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

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

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

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

(BREAK IN CONTINUITY OF SECTIONS)

545. ~~***553.***~~ **(RESERVED)**

546. *LICENSED* MIDWIFE (*LM*) SERVICES.
The Department will reimburse *licensed m*idwives for maternal and newborn services performed within the scope of their practice. This section of rules does not include midlevel practitioner services provided by a nurse midwife (NM) which are described in Sections 522 through 525 of these rules. *( )*

547. *LM* SERVICES: DEFINITIONS.

01. Licensed Midwife. An individual who holds a current license issued by the Idaho Board of Midwifery. *( )*

02. Board of Midwifery. The Idaho Board of Midwifery is located within the Idaho Bureau of Occupational Licensing and is the licensing authority for *L*M providers. *( )*

548. *LM* SERVICES: PARTICIPANT ELIGIBILITY.
A participant is eligible for *L*M services if *the participant* is pregnant, in the six (6) week postpartum period, or is a newborn up to six (6) weeks old. *( )*

549. *LM* SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. ( )

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered when provided by a CPM. ( )

03. Medication - Coverage and Limitations. *L*M providers may administer medication and bill Medicaid if the medication is a Medicaid covered service, and is also listed in the *L*M formulary in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." *( )*

550. *LM* SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each *L*M provider must: *( )*

01. Licensed. Have a current license as a *L*M from the Idaho Board of Midwifery or be licensed according to the regulations in the state where the services are provided. *( )*

02. Scope of Practice. Provide only those services that are within the scope of practice under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

551. *LM* SERVICES: PROVIDER REIMBURSEMENT.
Reimbursement for *L*M services will be the lesser of the billed amount, or 85% of the Department's physician fee schedule, The physician fee schedule is available from the Central Office for the Division of Medicaid as described in Section 005 of these rules, or online at: http:\\www.idmedicaid.com. *( )*

552. *LM* SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.

01. Licensure Required. Each *LM* provider must maintain *current* licensure with the Idaho Board of Midwifery. *( )*

02. Informed Consent Form Required. A signed copy of the participant's informed consent must be kept in the participant's record. ( )

03. Compliance with Board of Midwifery Requirements. The *L*M must adhere to all regulations listed in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." *( )*

04. Department Access to Practice Data. All practice data submitted to the Board of Midwifery according to the provisions in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery," must be made immediately available to the Department upon request. ( )

553. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1107

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of this temporary rule is **January 1, 2012.** The pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section 56-202(b) and 56-255, Idaho Code.

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

Under Section 56-255(5)(a)(xi) and (xii), Idaho Code, the Department is directed to limit benefits to eligible participants of the medical assistance program for physical therapy, speech therapy, and occupational therapy services. The changes limiting therapy services and aligning to meet the annual Medicare cap for the same services are effective on January 1, 2012. In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. The text of the pending rule is being adopted as proposed. The original text of the proposed rule was published in the October 5, 2011, Idaho Administrative Bulletin, Vol. 10-10, pages 386 through 388**.**

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

These changes are needed to meet statutory requirements that were adopted by the 2011 Legislature under House Bill 260.

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 anticipated fiscal impact will result in cost savings of $150,000 in state general funds for the SFY 2012, and $300,000 for each subsequent year.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated

rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 260.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rule, contact Jeanne Siroky (208) 364-1897.

DATED this 18th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of this temporary rule is **January 1, 2012**. The pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section 56-202(b) and 56-255, Idaho Code.

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

Under Section 56-255(5)(a)(xi) and (xii), Idaho Code, the Department is directed to limit benefits to eligible participants of the medical assistance program for physical therapy, speech therapy, and occupational therapy services. The changes limiting therapy services and aligning to meet the annual Medicare cap for the same services are effective on January 1, 2012. In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. The text of the pending rule is being adopted as proposed. The original text of the proposed rule was published in the October 5,

2011, Idaho Administrative Bulletin, Vol. 10-10, pages 386 through 388**.**

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

These changes are needed to meet statutory requirements that were adopted by the 2011 Legislature under House Bill 260.

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 anticipated fiscal impact will result in cost savings of $150,000 in state general funds for the SFY 2012, and $300,000 for each subsequent year.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 260.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rule, contact Jeanne Siroky (208) 364-1897.

DATED this 18th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), 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 Section 56-202(b) and 56-255, Idaho Code.

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

Thursday, October 13, 2011 6:00 p.m. (Local)	Monday, October 17, 2011 6:00 p.m. (Local)	Wednesday, October 19, 2011 6:00 p.m. (Local)
Health & Welfare Region IV 1720 Westgate Drive Suite A Rm. 131 Boise, ID	Health & Welfare Region I 1120 Ironwood Drive Suite 102, Large Conf. Rm. Coeur d'Alene, ID	Health & Welfare Region VII 150 Shoup Ave 2nd Floor Conf. Rm. Idaho Falls, ID

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

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

Under Section 56-255(5)(a)(xi) and (xii), Idaho Code, the Department is directed to limit benefits to eligible participants of the medical assistance program for physical therapy, speech therapy, and occupational therapy services. These services are to be aligned to meet the annual Medicare caps for the same services. These proposed rule changes limiting therapy services will be implemented on January 1, 2012.

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

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

The anticipated fiscal impact will result in cost savings of $150,000 in state general funds for the SFY 2012, and $300,000 for each subsequent year.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 260.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Siroky (208) 364-1897.

Anyone may submit written comments regarding the proposed rulemaking. All written

comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 8th day of September, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1107

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

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

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

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

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

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (4-2-08)

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

f. The services of therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or

take responsibility for the service. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. (4-2-08)

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

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

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

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

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

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

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

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

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

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

i. Group therapy in settings other than school-based services and developmental disability agencies. (4-2-08)

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

a. Physical therapy (PT) and ~~*Occupational Therapy. Each participant is limited to twenty-five (25) outpatient physical therapy visits and twenty-five (25) outpatient occupational therapy visits during any calendar year*~~ speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may ~~*prior*~~ authorize additional ~~*visits if additional physical*~~ therapy ~~*or occupational therapy*~~ services, ~~*or both,*~~ when the services are determined to be medically necessary and supporting documentation is provided to the Department. ~~*(4-2-08)*~~( )

b. ~~*Speech-Language Pathology Services. Each participant is limited to forty (40) outpatient speech-language pathology visits during any calendar year.*~~ Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may ~~*prior*~~ authorize additional ~~*visits if additional speech-*~~

~~*language pathology*~~ therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. ~~*(4-2-08)*~~( )

c. Exceptions to ~~*visit*~~ service limitations. ~~*(4-2-08)*~~( )

i. Therapy provided by home health agencies is subject to the limitations on home health ~~*visits*~~ services contained in Section 722 of these rules. ~~*(4-2-08)*~~( )

ii. Therapy provided through school-based services is not included in the ~~*visit*~~ service limitations under Subsection 732.04 of this rule. ~~*(4-2-08)*~~( )

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1108

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511, and 56-1601 through 56-1610, Idaho Code.

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

The Department is adopting rules clarifying Medicaid reimbursement policies for third party payor (insurance company) reimbursement of services. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011, Idaho Administrative Bulletin, Vol. 11-10, pages 389 through 391.

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

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

DATED this 18th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511, and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 19, 2011.

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

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

The Department is clarifying the rules related to Medicaid's reimbursement policies to providers for non-Medicare coordination of benefits when a third party payor (insurance company) reimburses a provider for services, or when the Department determines that a third party liability exists. These policies are determined under the guidance in the Centers for Medicare & Medicaid Services State Medicaid Manual (SSM), Section 3904.7.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being for clarification of current policies.

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

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 31st day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1108

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. (3-30-07)

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (3-30-07)

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. (3-30-07)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions of EPSDT and EPSDT-related services. (3-30-07)

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and (3-30-07)

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. (3-30-07)

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the exception of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT-related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT-related services, the claims will be paid and the resources billed by the Department. (3-30-07)

06. Accident Determination. When the participant's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (3-30-07)

07. Third Party Payments ~~***in Excess of Medicaid Limits***~~. ~~*The Department will not reimburse providers for services provided when the amount received by the provider from the third party payor is equal to or exceeds the level of reimbursement allowed by medical assistance for the services.*~~ The Department will pay the provider the lowest amount of the following:
~~*(3-30-07)*~~( )

a. The provider's actual charge for the service; or ( )

b. The maximum allowable charge for the service as established by the Department in its pricing file. If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation; or ( )

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. ( )

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (3-30-07)

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. (3-30-07)

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on his behalf. (3-30-07)

09. Subrogation of Legal Fees. (3-30-07)

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. (3-30-07)

b. If a settlement or judgment is received by the participant which does not specify portion of the settlement or judgment which is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1005

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendments to the temporary rule is **November 1, 2010**. This pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also House Concurrent Resolution No. 48 (2006).

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

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 clarify program elements and establish supervision and minimum professional requirements. Based on input from stakeholder work groups, provider qualifications were revised to more accurately define the clinical training expectation for psychosocial rehabilitation program providers.

The amendments to the temporary and pending rules reflect input from stakeholders and serve to simplify the requirements.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the November 3, 2010, Idaho Administrative Bulletin, Vol. 10-11, pages 92 through 97.

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

There is no fiscal impact to the state general fund due to these rule changes.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions

concerning the pending rule and the amendment to temporary rule, contact Patricia Guidry at (208) 364-1813.

DATED this 6th day of May, 2011.

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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.

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 Subsection 131.03.*c.iii.* of this rule. ~~*(3-19-07)*~~( )

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

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

06. Supervision. The agency must provide staff with adequate *case-specific* supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. An agency staff person without a Master's degree must be supervised by a~~*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. *PSR agency staff must be supervised in accordance with their applicable status as follows:* ( )

a. Certified Psychiatric Rehabilitation Practitioners (CPRP) may provide *case-specific* supervision to *other CPRP* applicants *when the supervising* CPRP is *directly* supervised by a Master's level *professional defined in Subsection 715.03*. ~~*(5-8-09)*~~( )

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

c. *The supervisors must ensure that the individual staff members demonstrate*

adequate competency to work with all populations assigned to them. *( )*

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

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

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

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

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

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

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

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

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

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

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

d. For a child whose parent or legal guardian does not participate in the services, the

provider must document efforts made to involve the parent or legal guardian and must make appropriate adjustments to the treatment plan to address the parent or legal guardian's lack of involvement. (5-8-09)

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

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

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

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

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

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

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

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

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

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

131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - AGENCY STAFF QUALIFICATIONS.

All agency staff delivering direct services must have at least one (1) of the following credentials:

(5-8-09)

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

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

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

a. *Individuals hired* ~~A~~a*s* of June 30, 2009, ~~*persons*~~ who are working as PSR Specialists *to* deliver~~*ing*~~ Medicaid-reimbursable mental health services may continue to do so until January 1, 2012~~,~~. ~~*at which time they*~~ *In order to continue working as a PSR specialist beyond this date, the worker* must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the *primary* population with whom *he* works in accordance with the requirements set by the USPRA~~ *be certified as PSR Specialists in accordance with USPRA requirements*~~. ~~*(5-8-09)*~~*( )*

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

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

i. Credential Required for PSR Specialists Working Primarily with Adults. *( )*

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

(2) Applicants who work primarily with adults, but also intend to work with

participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. *( )*

ii. Credential Required for PSR Specialists Working Primarily with Children. *( )*

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

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

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

~~*c. An applicant who meets the educational requirements under Subsection 131.03.b. of this rule may work as a PSR Specialist for a period not to exceed eighteen* (*18*) *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 (18) months, the worker must obtain the USPRA certification.* *(5-8-09)*~~

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*~~ *unless this* individual~~*s who have*~~ *has* obtained *one (1) of* the USPRA ~~*PSR Specialist certification*~~ credentials. ~~*(5-8-09)*~~*( )*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1103

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

House Bill 260, passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid-eligible participants' dental services. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 90 through 113.

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:

These rule changes are estimated to result in cost savings of $4,438,200 ($1,336,600 state funds, and $3,101,600 federal funds) for state fiscal year 2012.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 7th day of October, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is **July 1, 2011**.

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

House Bill 260 passed by the 2011 Legislature, directed the Department to limit benefits for Medicaid eligible participants' dental services. Section 56-255(5)(c), Idaho Code, provides children access to prevention, diagnosis and treatment services defined in federal law. Adult coverage is limited to medically necessary services with the exception that pregnant women have access to dental services that reflect evidence-based practice. This rulemaking reflects changes needed to meet statutory requirements.

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

These rule changes implement statutory changes adopted by the 2011 Legislature effective July 1, 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:

These rule changes are estimated to result in cost savings of $4,438,200 ($1,336,600 state funds, and $3,101,600 federal funds) for state fiscal year 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

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 August 24, 2011.

DATED this 8th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1103

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

01. Dental Services. Dental Services are provided as described under Sections 080 through 085~~9~~ of these rules. ~~(5-8-09)~~( )

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

03. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (3-19-07)

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

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

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

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

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

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

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

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

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

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (3-19-07)

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

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

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

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

076. -- 079. (RESERVED)

080. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
All participants who are eligible for Medicaid's Enhanced Plan dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. ( )

08~~0~~1. DENTAL SERVICES: DEFINITIONS.
~~*Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion. These services must be purchased from a licensed dentist or denturist.*~~ For the purposes of dental services covered in Sections 080 through 087 of these rules, the following definitions apply: ~~*(5-8-09)*~~( )

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.*~~ **Adult**. A person who is past the month of his twenty-first birthday. ~~*(5-8-09)*~~( )

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.~~ **Child**. A person from birth through the month of his twenty-first birthday. ~~(5-8-09)~~( )

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.~~ **Idaho Smiles**. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. ~~(5-8-09)~~( )

04. ~~***Participants Eligible for Other Programs**. Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services.~~ **Medicare/Medicaid Coordinated Plan (MMCP)**. Medical assistance in which Medicaid purchases services from a Medicare Advantage Organization (MAO) and provides other Medicaid-only services covered under the Medicaid Enhanced Plan in accordance with IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ~~(5-8-09)~~( )

08~~1~~2. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Enhanced Plan are eligible for Idaho Smiles dental benefits described in Section 083 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/ Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles. ( )

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

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

~~***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)~~

08~~2~~3. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may require authorization from the Idaho Smiles contractor. ( )

01. ~~Covered~~ Dental ~~Services~~ Coverage for Children. Children are covered for ~~D~~dental services ~~are covered by Medicaid as described in Section 081 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association.~~ that include: ~~(5-8-09)~~( )

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery; ( )

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. ( )

02. ~~Non-Covered Services.~~ ~~Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules.~~ **Children's Orthodontics Limitations.** Orthodontics are limited to children who meet the Enhanced Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. ~~(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.~~

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
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.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(5-8-09)

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.	

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
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)

05. Restorations. (5-8-09)

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 - RESTORATIONS**~~	
~~**Dental Code**~~	~~**Description**~~
~~**e. 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.~~

TABLE 082.05 - RESTORATIONS	
Dental Code	**Description**
f. 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. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
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.

TABLE 082.05 - RESTORATIONS	
Dental Code	**Description**
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)

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.
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.

TABLE 082.06 - ENDODONTICS	
Dental Code	**Description**
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)

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. 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.
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. 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)

08. Prosthodontics. (5-8-09)

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. 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. 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.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
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. 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.

TABLE 082.08.b. PROSTHODONTICS	
Dental Code	**Description**
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. 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. 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).
vi. 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. 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)

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.
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. Oral Surgery.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
a. Simple Extraction.	
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.

TABLE 082.11 - ORAL SURGERY	
Dental Code	**Description**
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. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. 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)

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.

TABLE 082.12 - ORTHODONTICS	
Dental Code	**Description**
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.
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)

13. Adjunctive General Services.

TABLE 082.13 - 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.
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.
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.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
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.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

(5-8-09)

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.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.
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.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.
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).

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.	
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.	

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.
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.

~~TABLE 082.15.a. DENTURIST PROCEDURE CODES~~	
~~Dental Code~~	~~Description~~
~~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)~~
~~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)~~

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 083.03 - ADULT DENTAL SERVICES CODES	
Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth

TABLE 083.03 - ADULT DENTAL SERVICES CODES	
Dental Code	**Description**
D7220	Removal of impacted tooth, soft tissue
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abcess
D7511	Incision and drainage of abcess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

( )

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem-focused exams, diagnostic, restorative, endontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at dental services. ( )

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. ( )

083~~3~~4. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. ( )

01. ~~***Dental Prior Authorization.*** *All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization 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.~~ **Administer Idaho Smiles**. The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. ~~*(5-8-09)*~~( )

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.*~~ The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. ~~*(5-8-09)*~~( )

03. ~~***Crowns.***~~ **Complaints and Appeals**. Complaints and appeals are handled through a process between Idaho Smiles and the Department that is in compliance with state and federal requirements. ~~*(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)*~~

08~~4~~5. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
~~*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.*~~ Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ~~*(5-8-09)*~~( )

08~~5~~6. 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. 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.*~~ The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. ~~*(5-8-09)*~~( )

087. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. ( )

08~~6~~8. -- 089. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1104

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is **July 1, 2011**. This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511 and 56-1601 through 56-1610, Idaho Code.

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

Sections 013 and 223 have been added to this docket in the pending rule to define and clarify patient day for both a nursing facility and an intermediate care facility for persons with intellectual disabilities (ICF/ID). Changes have been made to the nursing facility cost limits based on cost reports for clarification. Rules regarding cost surveys have been amended to require Medicaid providers to participate when the Department requests a periodic cost survey instead of conducting a cost survey every five years.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 114 through 124.

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 fiscal impact of this docket represents $1,023,740 of the $4,700,000 general fund savings related to pricing and inflation freeze changes identified in HB 260. This savings was included in the Department's SFY 2012 appropriations.

Changes for reimbursement methodologies to mental health clinics, developmental disability agencies, and rehabilitative mental health service providers, are designed to be

budget neutral and have no anticipated fiscal impact to the state general fund.

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

DATED this 8th day of November, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564
fax: (208) 334-6558
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511 and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

Rule changes in this docket implement legislative intent language in House Bill 260 passed by the 2011 Legislature regarding nursing facilities and intermediate care facilities for people with intellectual disabilities. The legal authority section for repealed, amended, and new statutes is also being updated in this rulemaking. Other rule changes in this docket continue reimbursement methodologies for mental health clinics, developmental disability agencies and rehabilitative mental health service providers that were implemented in 2010.

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 for the following reasons:

These rule changes implement statutory changes adopted by the 2011 Legislature in House Bill 260, effective July 1, 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 fiscal impact of this docket represents $1,023,740 of the $4,700,000 general fund savings related to pricing and inflation freeze changes identified in HB 260. This savings was included in the Department's SFY 2012 appropriations.

Changes for reimbursement methodologies to mental health clinics, developmental disability agencies, and rehabilitative mental health service providers, are designed to be budget neutral and have no anticipated fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

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

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 7th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1104

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, and 56-1610, Idaho Code. ~~*(3-19-07)*~~( )

02. General Administrative Authority. Title XIX and Title XXI, of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-19-07)

03. Administration of the Medical Assistance Program. (3-19-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-19-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-19-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. ~~*(3-19-07)*~~( )

04. Fiscal Administration. (3-19-07)

a. Fiscal administration of these rules is authorized by Title XIX and Title XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated by reference in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-19-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. *( )*

a. For ~~*a nursing facility or an*~~ ICF/ID, a calendar day of care ~~*which will*~~ includes the day of admission and excludes the day of discharge, unless discharge occurs after 3:00 p.m. or it is the date of death~~,~~. ~~*except that, w*~~*W*hen admission and discharge occur on the same day, one (1) day of care ~~*will be*~~ *is* deemed to exist. ~~*(3-19-07)*~~( )

b. *For a nursing facility, a calendar day of care includes the day of admission and*

excludes the day of discharge, unless it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. *( )*

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). 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 participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.” (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility’s rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. PRM. The Provider Reimbursement Manual. (3-19-07)

12. Property. The homestead and all personal and real property in which the

participant has a legal interest. (3-19-07)

13. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

15. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (7-1-11)

24. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

25. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

26. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

27. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

28. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

29. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

30. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

31. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

32. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

33. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

34. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

35. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

36. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

37. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

38. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

39. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

40. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 “Rules Governing Uniform Assessments of State-Funded Clients.” (3-19-07)

41. Updated Assessments. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participant’s file that the assessment continues to reflect the participant’s current status and assessed needs. (7-1-11)T

42. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

43. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

44. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

45. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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: ( )

a. The mental health clinic's actual charge; or ( )

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. ( )

02. Reimbursement. ( )

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. ( )

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. ( )

03. Cost Survey. *Medicaid Mental Health providers are required to participate in periodic state cost surveys when requested by the Department. Providers must disclose the costs of all employment-related expenditures, program-related costs, general and administrative costs. Mental health providers that refuse or fail to respond to the periodic state surveys can be disenrolled as a Medicaid provider.* ( )

(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. ( )

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. ( )

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. ( )

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. ( )

09. Cost Survey. *Medicaid Mental Health providers are required to participate in periodic state cost surveys when requested by the Department. Providers must disclose the costs of all employment-related expenditures, program-related costs, general and administrative costs. Mental health providers that refuse or fail to respond to the periodic state surveys can be disenrolled as a Medicaid provider.* *( )*

(BREAK IN CONTINUITY OF SECTIONS)

223. NURSING FACILITY: CRITERIA FOR DETERMINING NEED.
The participant requires nursing facility level of care when an adult meets one (1) of the Resource Utilization Group (RUG III) classifications or when a child meets one (1) or more of the criteria described in Subsections 223.02, 223.03, 223.04 or 223.05 of this rule. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years of age. (4-2-08)

01. Required Assessment for Adults. A standard assessment will be approved by the Department for all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. (4-2-08)

02. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-19-07)

03. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (3-19-07)

04. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-19-07)

05. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.02, 223.03, and 223.04 of these rules, plus consideration of the developmental milestones, based on the age of the child, the Department's RMS will determine nursing facility level of care. (4-2-08)

06. Conditions of Payment. (3-19-07)

a. As a condition of payment by the Department for long-term care on behalf of medical assistance participants, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. (3-19-07)

b. Payment by the Department for the cost of long-term care ~~*is to include*~~ *excludes* the date of the participant's discharge~~*, only if the discharge occurred after 3:00 p.m.*~~ *unless the day of discharge occurs on the same day as admission; then, one (1) day of care is deemed to exist. When a Medicaid patient dies in a nursing home, the date of death is covered, regardless of the time of death.* ~~*(3-19-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

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)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.

Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.0~~9~~8 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, 2011, through June 30, 2012, rates will be calculated using cost reports ended in calendar year 2010 with no allowance for inflation to the rate period of July 1, 2011, through June 30, 2012. ~~*(5-8-09)*~~( )

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. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

07. Property Reimbursement. The property reimbursement component is calculated

in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

08. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these 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, 2011, through June 30, 2012, the direct and indirect cost limits *were calculated using the most recent finalized cost reports adjusted to the midpoint of* the cost *reporting year's end in calendar year* 2010, *to allow for no inflation to the rate year.* ~~*(5-8-09)*~~*( )*

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)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis ~~*according to Section 39-5606, Idaho Code*~~. 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)*~~( )

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (3-29-10)

04. Payment for Personal Assistance Agency. (3-4-11)

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR ~~*in accordance with Section 39-5606, Idaho Code*~~. For State Fiscal Year 201~~1~~2, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 201~~0~~1.

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

~~*(3-4-11)*~~( )

b. Beginning with State Fiscal Year 201~~1~~3, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. ~~(3-4-11)~~( )

c. Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component. (3-4-11)

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR ~~*in accordance with Section 39-5606, Idaho Code*~~. Beginning with State Fiscal Year 201~~1~~3, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

~~*(3-4-11)*~~( )

(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~~2 (July 1, 20~~09~~11 through June 30, 201~~0~~2) ~~*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 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. ~~*(3-29-10)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

659. DDA SERVICES: PROVIDER REIMBURSEMENT.
~~*Payment for agency services must be in accordance with rates established by the Department.*~~
~~*(3-19-07)*~~

01. Reimbursement. ( )

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. ( )

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 659.02 of this rule. *( )*

02. Cost Survey. *Medicaid DDA providers are required to participate in periodic state cost surveys when requested by the Department. Providers must disclose the costs of all employment-related expenditures, program-related costs, general and administrative costs. DDA providers that refuse or fail to respond to the periodic state surveys can be disenrolled as a Medicaid provider.* *( )*

(BREAK IN CONTINUITY OF SECTIONS)

706. ADULT 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. ( )

05. Cost Survey. *Medicaid DD providers are required to participate in periodic state cost surveys when requested by the Department. Providers must disclose the costs of all employment-related expenditures, program-related costs, general and administrative costs. DD providers that refuse or fail to respond to the periodic state surveys can be disenrolled as a Medicaid provider.* *( )*

(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)*~~( )

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: ( )

a. Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment-related expenditures; ( )

b. Non-productive time including vacation, sick time, and holiday; and ( )

c. An indirect general and administrative cost based on a survey as described in Subsection 736.10 of this rule. ( )

10. Cost Survey. *Medicaid service coordination providers are required to participate in periodic state cost surveys when requested by the Department. Providers must disclose the costs of all employment-related expenditures, program-related costs, general and administrative costs. Service coordination providers that refuse or fail to respond to the periodic state surveys can be disenrolled as a Medicaid provider.* *( )*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1105

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

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

Rule changes are being made to continue cost-saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 125 through 190.

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

The estimated cost savings for these rule changes are as follows: $6,593,000 to continue cost saving measures begun in SFY 2011; in addition, under HB 260: $2,270,000 for reduction in adult psycho-social rehabilitation (PSR) hours, and $2,000,000 through refinements to the developmental disabilities (DD) individual budget modification process, requirements and criteria in order to respond to requests for individual budget modifications only when health and safety issues are identified for adult developmental disabilities services.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is $10,863,000, and was included in the Department's appropriations for SFY 2012.

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

DATED this 1st day of November, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

Rule changes are needed to continue cost saving measures begun during SFY 2011, as well as align the rules with House Bill 260 passed by the 2011 Legislature, and codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

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

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

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

The estimated cost savings for these rule changes are as follows: $6,593,000 to continue cost saving measures begun in SFY 2011; in addition, under HB 260: $2,270,000 for reduction in adult psycho-social rehabilitation (PSR) hours, and $2,000,000 through refinements to the developmental disabilities (DD) individual budget modification process, requirements and criteria in order to respond to requests for individual budget modifications only when health and safety issues are identified for adult developmental disabilities services.

The total estimated cost savings for SFY 2012 to the state general fund for these rule changes is $10,863,000, and was included in the Department's appropriations for SFY 2012.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

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 Paul Leary at (208) 364-1836.

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 August 24, 2011.

DATED this 13th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1105

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)

013. DEFINITIONS: P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. For a nursing facility or an ICF/ID, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). 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 participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.” (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility’s rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and

duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. PRM. The Provider Reimbursement Manual. (3-19-07)

12. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

13. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

15. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. Raw Food. Food used to meet the nutritional needs of the residents of a facility,

including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (7-1-11)

24. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

25. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

26. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

27. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

28. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

29. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

30. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

31. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the

states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

32. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

33. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

34. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

35. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

36. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

37. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

38. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

39. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

40. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

41. Updated Assessments. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participant's file that the assessment continues to reflect the participant's current status and assessed needs. ( )

4~~1~~2. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

4~~2~~3. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

4~~3~~4. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which

conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

4~~4~~5. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(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 a participant's diagnosis and disposition for treatment. ( )

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~~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*~~ serious and persistent mental illness (SPMI) whose functioning is sufficiently disrupted ~~*so as*~~ to the extent that it interferes with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. ~~*(3-19-07)*~~( )

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)

243. 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)

254. 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)

265. 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)

276. 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)*~~( )

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*~~ 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)*~~( )

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)*~~( )

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)*~~( )

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)*~~( )

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)~~( )

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, their treatment plan must incorporate the need for psychiatric services identified by the comprehensive

diagnostic assessment. For children, their treatment plan must incorporate the substantial impairment areas identified by the CAFAS. Participant's goals may include any of the following: ~~*(5-8-09)*~~( )

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)*~~( )

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)*~~( )

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)*~~( )

(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)~~( )

~~**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)~~( )

~~**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. ( )

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)~~( )

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 for eligible participants up to twenty-one (21) years of age. For participants aged twenty-one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. ~~*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)~~( )

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)~~( )

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)*~~( )

~~***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)*~~( )

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~~*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)*~~( )

~~***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)*~~

0~~3~~2. **Service Availability**. Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis. (5-8-09)

0~~4~~3. **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)*~~( )

0~~5~~4. **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)~~( )

0~~6~~5. 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)

0~~7~~6. 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)

0~~8~~7. 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)~~( )

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)*~~( )

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. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled

care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (3-19-07)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

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)

12. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-19-07)

13. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

14. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

16. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

17. Residential Habilitation Supported Living Provider Qualifications. Residential habilitation supported living services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in the~~ir own~~ home of the participant (supported living) must be ~~certified~~ employed 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 qualified 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*~~ is 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*~~**19. Residential Habilitation Program Coordination for Certified Family Home Providers.** When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes" and must receive residential habilitation program coordination from a qualified program coordinator approved by the Department. Non-compliance with the certification process is cause for termination of the provider agreement or contract. ~~*(3-30-07)*~~( )

~~*19*~~**20. 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)

2~~*0*~~**1. 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~~2. 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)

507. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION (PA).
The purpose of ~~*Behavioral Health*~~ adult developmental disability services ~~*P*~~prior ~~*A*~~authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. ~~*(3-19-07)*~~( )

508. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION~~*S*~~: 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)~~

143. 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)

154. 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)

165. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

176. 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)

187. 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)

198. 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)

2019. 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)

210. 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)

221. 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)

232. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

243. 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)

254. 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)

509. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.
The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/ID level of care for waiver services in accordance with Section 584 of these rules. ~~*(3-19-07)*~~( )

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

a. The assessment process must be completed; and (3-19-07)

b. The assessor must provide the results of the assessment to the participant. (3-19-07)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A SIB-R will be administered by the Department for use in this determination. (3-19-07)

04. ICF/ID Level of Care Determination for Waiver Services. The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (3-19-07)

510. (RESERVED)

511. ~~*INDIVIDUALS WITH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: - COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid ~~*behavioral health*~~ developmental disability services for adults: ~~*(3-19-07)*~~( )

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

02. Developmental Disabilities Agency Services. Developmental Disabilities Agency services as described in Sections 649 through 659 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; and (7-1-11)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. ~~*BEHAVIOR HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of DDA services and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. ~~(3-19-07)~~( )

a. A medical, social and developmental history for each adult participant 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. ( )

b. A medical social and developmental history for children is required when the child is accessing DDA services for the first time, and must reflect accurate information about the participant's status. ( )

c. After the initial medical social development history for children, additional Medical Social and Development History services for children will be reimbursed if a qualified professional determines that it no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules. ( )

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. ( )

b. The SIB-R for children is required for all children accessing DDA services for the first time. ( )

c. After the initial SIB-R assessment for children, additional SIB-R assessments will be reimbursed if a qualified professional determines that the assessment no longer reflects the current status of the participant. Please refer to Subsection 655 of these rules. ( )

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~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. ~~(3-19-07)~~( )

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)*~~( )

e. The provider will ~~I~~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)*~~ Department, 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)

~~***09. 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*~~**08. Informed Consent**. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

~~*11*~~**09. Provider Implementation Plan**. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change

complete with the date and title. (3-19-07)

1~~2~~0. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change~~s in a participant's need or demonstrated outcomes~~ to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~(3-19-07)~~( )

1~~3~~1. 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)

1~~4~~2. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service.

(3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. ~~(3-19-07)~~( )

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

1~~5~~3. ~~*Reconsiderations,*~~ Complaints~~,~~ and Administrative Appeals. ~~(3-19-07)~~( )

~~***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.*~~ A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(3-19-07)~~( )

514. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. ~~(3-19-07)~~( )

~~***01. Methodology for Developing Participant Budget Prior to October 1, 2006****. The participant budget is developed using the following methodology:* (3-19-07)~~

~~***a.*** *Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services;* ***(3-19-07)***~~

~~***b.*** *Review all assessment information identified in Section 512 of these rules;* ***(3-19-07)***~~

~~***c.*** *Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 514.01.c.). There are six (6) levels of support, each corresponding to a support score range.*~~

~~***TABLE 514.01.c. - LEVEL OF SUPPORT***~~	
~~***Support Score Range***~~	~~***Level of Support***~~
~~*1-24*~~	~~*Pervasive*~~
~~*25-39*~~	~~*Extensive*~~
~~*40-54*~~	~~*Frequent*~~
~~*55-69*~~	~~*Limited*~~
~~*70-84*~~	~~*Intermittent*~~
~~*85-100*~~	~~*Infrequent*~~

~~***(3-19-07)***~~

~~***d.*** *Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service;* ***(3-19-07)***~~

~~***02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006****. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs.* ***(3-19-07)***~~

0~~3~~1. **Individualized Budget Beginning on October 1, 2006**. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, ~~*and other individual factors*~~ related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. ~~*(3-29-10)*~~( )

~~***a.*** *During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the*~~

~~*calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology.*~~
~~*(3-19-07)*~~

~~*b*~~**a.** The Department notifies each participant of his set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may ~~*request reconsideration of*~~ appeal the set budget amount.~~*(3-19-07)*~~( )

~~*c*~~**b.** Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's ~~*individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget*~~ condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. ~~*(3-19-07)*~~( )

0~~4~~2. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the

threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

515. ~~*BEHAVIORAL HEALTH*~~ ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. (3-19-07)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-19-07)

03. Exception Review. In order to assure health and safety of the participant, ~~T~~the Department will complete an ~~*clinical*~~ exception review of plans of service ~~*that*~~ requesting residential habilitation High or Intense Supported Living when the request exceeds the assigned budget authorized by the assessor, ~~*or are inconsistent with the participant's assessed needs*~~ and

when the services requested on the plan are required, based on medical necessity in accordance with Subsection 012.14 of these rules. ~~*The supporting documentation must demonstrate the medical necessity of services in the plan of service.*~~ ~~*(3-19-07)*~~( )

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (3-19-07)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

581. ICF/ID: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the ~~*Regional Nurse Reviewer (RNR)*~~ Department has determined that the individual meets the criteria for ICF/ID services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. ~~*(3-19-07)*~~( )

582. ICF/ID: DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.
Applications for Medicaid payment of an individual with an intellectual disability or related condition, in an ICF/ID will be through the Department~~*'s RMS staff*~~. All required information necessary for a medical entitlement determination must be submitted to the ~~*Regional Medicaid Services*~~ Department before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/ID level of care. ~~*(3-19-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

651. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. (7-1-11)

01. Required DDA Services. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided

by qualified employees of the agency or through a formal written agreement. (7-1-11)

a. Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (7-1-11)

b. When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. (7-1-11)

02. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. Developmental therapy will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. ~~(7-1-11)~~( )

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-11)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-11)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-11)

03. Psychotherapy Services. The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to

deliver the service: (7-1-11)

a. Individual psychotherapy; (7-1-11)

b. Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and (7-1-11)

c. Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. (7-1-11)

d. Psychotherapy services~~, *alone or in combination with supportive counseling,*~~ are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. ~~*(7-1-11)*~~( )

e. Psychotherapy services must be provided by one (1) of the following qualified professionals: (7-1-11)

i. Licensed Psychiatrist; (7-1-11)

ii. Licensed Physician; (7-1-11)

iii Licensed Psychologist; (7-1-11)

iv. Licensed Clinical Social Worker; (7-1-11)

v. Licensed Clinical Professional Counselor; (7-1-11)

vi. Licensed Marriage and Family Therapist; (7-1-11)

vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; (7-1-11)

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.e.i. through 651.03.e.vii. of this rule; (7-1-11)

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

x. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (7-1-11)

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the

Idaho State Board of Psychologist Examiners." (7-1-11)

04. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

05. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

06. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Speech-language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. (7-1-11)

07. Optional Services. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, ~~*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 657 of these rules. ~~*(7-1-11)*~~( )

08. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency, and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (7-1-11)

09. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. (7-1-11)

a. Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. (7-1-11)

b. On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. (7-1-11)

c. Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: (7-1-11)

i. Psychiatrist; (7-1-11)

ii. Physician or other practitioner of the healing arts; (7-1-11)

iii. Psychologist; (7-1-11)

iv. Clinical social worker; or (7-1-11)

v. Clinical professional counselor. (7-1-11)

10. Community Crisis Supports. Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. (7-1-11)

~~***11. Collateral Contact***. *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 be:* *(7-1-11)*~~

~~***a.*** *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.* *(7-1-11)*~~

~~***b.*** *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.* *(7-1-11)*~~

~~***c.*** *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.* *(7-1-11)*~~

1~~2~~1. Intensive Behavioral Intervention. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. (7-1-11)

a. IBI is limited to a lifetime limit of thirty-six (36) months. (7-1-11)

b. The DDA must receive prior authorization from the Department prior to delivering IBI services. (7-1-11)

c. IBI must only be delivered on an individualized, one-to-one (1 to 1) basis.(7-1-11)

d. Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. ( )

~~***d***~~**e.** ~~*Established Developmental Therapy Program.*~~ After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services. ~~*(7-1-11)*~~( )

~~***e***~~**f.** ~~*Exception.*~~ Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of this rule. ~~*(7-1-11)*~~( )

~~***f***~~**g.** ~~*IBI Consultation.*~~ IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. ~~*(7-1-11)*~~( )

~~***13. 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.* *(7-1-11)*~~

~~***a.*** *Psychological Assessment. The initial and ongoing need for the service of supportive counseling must be recommended in a current psychological assessment.* *(7-1-11)*~~

~~***b.*** *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.* *(7-1-11)*~~

~~***c.*** *Staff Qualifications. Supportive counseling must be provided by a professional listed under Subsection 651.03.e. of these rules or by a licensed social worker (LSW).* *(7-1-11)*~~

1~~*4*~~2. **Excluded Services**. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

1~~*5*~~3. **Limitations on DDA Services**. DDA ~~*T*~~therapy services may not exceed the limitations as specified below. ~~*(7-1-11)*~~( )

a. The combination of therapy services listed in Subsections 651.02 through 651.06, and 651.1~~*2*~~1~~*, and 651.13*~~ of this rule must not exceed twenty-two (22) hours per week. ~~*(7-1-11)*~~( )

b. Therapy services listed in Subsections 651.02 through 651.06, and 651.121~~, and 651.13~~ of this rule, provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week.~~(7-1-11)~~( )

c. When an HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (7-1-11)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

655. DDA SERVICES: PROCEDURAL REQUIREMENTS.

01. 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. Psychological assessment benefits are separately limited to four (4) hours annually. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: ~~(7-1-11)~~( )

a. Comprehensive Developmental Assessment; (7-1-11)

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 Subsection 655.01 of this rule; ~~(7-1-11)~~( )

c. Occupational Therapy Assessment; (7-1-11)

d. Physical Therapy Assessment; (7-1-11)

e. Speech and Language Assessment; (7-1-11)

f. Medical/Social History; and (7-1-11)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (7-1-11)

02. Comprehensive Assessments Conducted by the DDA. Assessments must be

conducted by qualified professionals defined under Section 657 of these rules for the respective discipline or areas of service. (7-1-11)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

v. For medical or psychiatric assessments, formulate a diagnosis. For psychological assessments, formulate a diagnosis and recommend the type of therapy necessary to address the participant's needs. For other types of assessments, recommend the type and amount of therapy necessary to address the participant's needs. (7-1-11)

b. Current Assessments Required. When the DDA determines developmental disabilities eligibility, current assessments must be completed or obtained as necessary. (7-1-11)

c. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

d. Assessment must be completed within forty-five (45) days. (7-1-11)

i. With the exception noted under Subsection 655.02.d.ii. of this rule, each assessment must be completed within forty-five (45) calendar days of the date it was recommended by the physician or other practitioner of the healing arts. If the assessment is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. (7-1-11)

ii. This forty-five (45) day requirement does not apply to participant plans of service authorized under Sections 507 through 515 of these rules. (7-1-11)

03. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. (7-1-11)

a. ~~*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. ~~*(7-1-11)*~~( )

b. ~~*Updated Assessments.*~~ Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the

participant's current status in that service area. If, during the required review of the assessment(s), the latest assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so. ~~(7-1-11)~~( )

c. ~~*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. ~~(7-1-11)~~( )

d. ~~*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 mental retardation. IQ testing must be reconducted on a frequency determined and documented by the agency psychologist or at the request of the Department. ~~(7-1-11)~~( )

e. ~~*Completion of Assessments.*~~ Assessments must be completed or obtained prior to the delivery of therapy in each type of service. ~~(7-1-11)~~( )

f. ~~*Psychological Assessment.*~~ A current psychological assessment must be ~~*completed or obtained*~~ updated in accordance with Subsection 655.03.f. of these rules: ~~(7-1-11)~~( )

~~*i. When the participant is receiving a behavior modifying drug(s);* (7-1-11)~~

i~~*i*~~. Prior to the initiation of restrictive interventions to modify inappropriate behavior(s); (7-1-11)

~~*iii. Prior to the initiation of supportive counseling;* (7-1-11)~~

i~~*v*~~i. When it is necessary to determine eligibility for services or establish a diagnosis; (7-1-11)

~~*v*~~iii. When a participant has been diagnosed with mental illness; or (7-1-11)

~~*v*~~iv. When a child has been identified to have a severe emotional disturbance. (7-1-11)

04. Assessments for Adults. DDAs must obtain assessments required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 of these rules. All specific skill assessments must be conducted in accordance with Subsection 655.06 of these rules. (7-1-11)

05. Types of Comprehensive Assessments. (7-1-11)

a. Comprehensive Developmental Assessment. A comprehensive developmental assessment must be conducted by a qualified Development Specialist and reflect a person's developmental status in the following areas: (7-1-11)

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. The requirements for the comprehensive IBI assessment are found under Subsection 656.03 of these rules. (7-1-11)

c. Occupational Therapy Assessment. Occupational therapy assessments must be conducted by an occupational therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. (7-1-11)

d. Physical Therapy Assessment. Physical therapy assessments must be conducted by a physical therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. (7-1-11)

e. Speech and Language Assessment. Speech and language assessments must be conducted by a Speech-Language Pathologist who is qualified under Section 657 of these rules. (7-1-11)

f. Medical Assessments. Medical assessments must be completed by a physician or other practitioner of the healing arts who is qualified in accordance with Section 657 of these rules and accurately reflects the current status and needs of the person. (7-1-11)

g. Medical/Social History. Medical/social histories must be completed by a licensed social worker or other qualified professional working within the scope of his license. The medical/social history is a narrative report that must include: (7-1-11)

i. Medical history including age of onset of disability, prenatal and postnatal birth issues, other major medical issues, surgeries, and general current health information; (7-1-11)

ii. Developmental history including developmental milestones and developmental treatment interventions; (7-1-11)

iii. Personal history including social functioning/social relationships, recreational activities, hobbies, any legal and criminal history, and any history of abuse; (7-1-11)

iv. Family history including information about living or deceased parents and siblings, family medical history, relevant family cultural background, resources in the family for the participant; (7-1-11)

v. Educational history including any participation in special education; (7-1-11)

vi. Prevocational or vocational paid and unpaid work experiences; (7-1-11)

vii. Financial resources; and (7-1-11)

viii. Recommendation of services necessary to address the participant's needs. (7-1-11)

h. Hearing Assessment. A hearing assessment must be conducted by an audiologist who is qualified under Section 657 of these rules. (7-1-11)

i. Psychological Assessment. A psychological assessment includes psychological testing for diagnosis and assessment of personality, psychopathology, emotionality, or intellectual abilities (IQ test). The assessment must include a narrative report. Psychological assessment encompasses psychological testing and the psychiatric diagnostic interview. (7-1-11)

j. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of a person’s behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses, or functional impairments. (7-1-11)

i. Psychological testing may be provided when in direct response to a specific assessment question (7-1-11)

ii. The psychological report must contain the reason for the performance of this service. (7-1-11)

iii. Agency staff may deliver this service if they meet one (1) of the following qualifications: (7-1-11)

(1) Licensed Psychologist; (7-1-11)

(2) Psychologist Extender; or (7-1-11)

(3) A qualified therapist listed in Subsection 651.03.e. of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (7-1-11)

k. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must be conducted in accordance with Subsection 651.09 of these rules. (7-1-11)

06. Requirements for Specific Skill Assessments. Specific skill assessments must: (7-1-11)

a. Further Assessment. Further assess an area of limitation or deficit identified on a

comprehensive assessment. (7-1-11)

b. Related to a Goal. Be related to a goal on the IPP, ISP, or IFSP. (7-1-11)

c. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective disciplines as defined in this chapter. (7-1-11)

d. Determine a Participant's Skill Level. Be conducted for the purposes of determining a participant's skill level within a specific domain. (7-1-11)

e. Determine Baselines. Be used to determine baselines and develop the program implementation plan. (7-1-11)

07. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. When a participant receives developmental therapy, documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-11)

b. Additional Requirements for Participants Eighteen Years or Older. For participant's eighteen (18) years of age or older, DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-11)

c. Additional Requirements for Participants Seven Through Sixteen. For participants ages seven (7) through sixteen (16), the DDA must also document that the child has been referred to the local school district in accordance with the collaboration requirements in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

d. Additional Requirements for Participants Birth to Three Years of Age. For participants birth to age three (3), the following are required in addition to those requirements in Subsection 654.01 of these rules: (7-1-11)

i. Documentation of the six (6) month and annual reviews; (7-1-11)

ii. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to ensure service continuity and access to community services as early intervention services end at age three (3); (7-1-11)

iii. Documentation that participant rights have been met in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

iv. Documentation of participation in the transition meeting with the school district; and (7-1-11)

v. Documentation of consultation with other service providers who are identified on the IFSP. (7-1-11)

08. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements: (7-1-11)

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic

methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

658. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.

01. Standards for Paraprofessionals Providing Developmental Therapy and IBI. When a paraprofessional provides either developmental therapy or IBI, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 657 of these rules. A paraprofessional providing IBI must be supervised by an IBI professional; a paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. Paraprofessionals providing developmental therapy to children birth to three (3) years of age must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. For paraprofessionals to provide developmental therapy or IBI in a DDA, the agency must adhere to the following standards: (7-1-11)

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service, 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. ~~*(7-1-11)*~~( )

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or more often if necessary: (7-1-11)

i. Give instructions; (7-1-11)

ii. Review progress; and (7-1-11)

iii. Provide training on the program(s) and procedures to be followed. (7-1-11)

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-11)

d. Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent (10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI. (7-1-11)

e. Additional Training Requirements for IBI Professionals and IBI Paraprofessionals. Qualified IBI professionals and IBI paraprofessionals must complete and pass a Department-approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of IBI and ethical standards. Specifically, the curriculum must include: (7-1-11)

i. Assessment of individuals; (7-1-11)

ii. Behavioral management; (7-1-11)

iii. Services or treatment of individuals; (7-1-11)

iv. Supervised practical experience; and (7-1-11)

v. Successful completion of a student project that includes an observation of demonstrated competencies for all individuals applying for initial certification or recertification after July 1, 2003. (7-1-11)

f. Continuing Training Requirements for IBI Professionals and IBI Paraprofessionals. Each IBI professional and IBI paraprofessional, in order to maintain certification, must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. (7-1-11)

i. The initial IBI certification training meets the yearly training requirement for the calendar year in which the IBI professional or paraprofessional was first certified. (7-1-11)

ii. If the individual has not completed the required training during any yearly training period, he may not provide IBI services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

iii. An individual may remain IBI certified, despite being unable to bill for services, through two (2) consecutive annual training periods during which that individual has deficient training hours. A DDA may begin billing for the certified IBI Professional or Paraprofessional again after the required training hours are accumulated. (7-1-11)

iv. If an individual completes three (3) consecutive annual training periods without having accumulated sufficient training to satisfy the training requirement for the first of those periods, that individual's IBI certification is automatically rescinded and will no longer be recognized. To be recertified, the individual must retake the state IBI exam and complete the IBI Student Project, if not previously completed. (7-1-11)

02. General Staffing Requirements for Agencies. (7-1-11)

a. Administrative Staffing. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous

and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (7-1-11)

i. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-11)

ii. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (7-1-11)

b. Other required staffing. The agency must have available, at a minimum, the following personnel, qualified in accordance with Section 657 of these rules, as employees of the agency or through formal written agreement: (7-1-11)

i. Speech-language pathologist or audiologist; (7-1-11)

ii. Developmental Specialist; (7-1-11)

iii. Occupational therapist; (7-1-11)

iv. Physical therapist; (7-1-11)

v. Psychologist; and (7-1-11)

vi. Social worker, or other professional qualified to provide the required services under the scope of his license. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or

threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

d. Residential Habilitation services will not be reimbursed if a participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services. ( )

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 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

13. 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)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When ~~*R*~~residential habilitation services ~~*must be*~~ are provided by an agency, ~~*that is*~~ the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and ~~*is*~~ must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the~~*ir own*~~ home of the

participant (supported living) must be ~~certified~~ employed 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: ~~(3-19-07)~~( )

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. ~~(3-19-07)~~( )

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: ~~(3-19-07)~~( )

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment ~~*or affiliation*~~ with the residential habilitation agency and include at a minimum: ~~*(3-19-07)*~~( )

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

~~***f.*** *When residential habilitation services are provided in the provider's home, the provider's home 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's provider agreement.* *(3-19-07)*~~

02. Residential Habilitation -- Certified Family Home (CFH). ( )

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation

program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides. ( )

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: ( )

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

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; ( )

iii. Have current CPR and First Aid certifications; ( )

iv. Be free from communicable diseases; ( )

v. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. ( )

vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and ( )

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. ( )

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. ( )

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: ( )

i. Purpose and philosophy of services; ( )

ii. Service rules; ( )

iii. Policies and procedures; ( )

iv. Proper conduct in relating to waiver participants; ( )

v. Handling of confidential and emergency situation that involve the waiver participant; ( )

vi. Participant rights; ( )

vii. Methods of supervising participants; ( )

viii. Working with individuals with developmental disabilities; and ( )

ix. Training specific to the needs of the participant. ( )

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: ( )

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; ( )

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; ( )

iii. Feeding; ( )

iv. Communication; ( )

v. Mobility; ( )

vi. Activities of daily living; ( )

vii. Body mechanics and lifting techniques; ( )

viii. Housekeeping techniques; and ( )

ix. Maintenance of a clean, safe, and healthy environment. ( )

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. ( )

02~~2~~3. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

03~~3~~4. Respite. Providers of respite care services must meet the following minimum

qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

04~~5~~5. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05~~6~~6. Transportation. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

06~~7~~7. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07~~8~~8. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission

standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

0~~8~~9. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

~~09~~10. Home Delivered Meals. Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must: (7-1-11)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

1~~0~~1. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

1~~1~~2. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

1~~2~~3. Adult Day Care. Providers of adult day care services must ~~*be employed by or be affiliated with the residential habilitation agency that provides*~~ notify the Department or its contractor for residential habilitation program coordination, ~~*for*~~ on behalf of the participant, if the ~~*service*~~ adult day care is provided in a certified family home other than the participant's primary residence~~,~~. The adult day care provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: ~~*(3-19-07)*~~( )

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

1~~3~~4. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (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)*~~( )

(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 four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

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

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.13 - CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is **July 1, 2011**. This pending rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, and, 56-250 through 56-257, Idaho Code; also House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

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

Rule changes are being made to align the rules with House Bill 260 passed by the 2011 Legislature. In Section 56-255(3)(f), Idaho Code, as amended, the Department is directed to respond to requests for budget modifications only when health and safety issues are identified and meet the criteria as defined in rule.

The Department is refining the developmental disabilities individual budget modification process, and related requirements and criteria. This will enable the Department to respond to requests for individual developmental disabilities budget modifications only when health and safety issues are identified.

Amendments are being made to the temporary and pending rule to better define when a budget redetermination could be made for children receiving services under the family-directed option, and distinguish more clearly the difference between the adult and children's budget methodologies.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 191 through 198.

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

Self-Directed Services come under Developmental Disabilities Waiver Services found in IDAPA 16.03.10. The total estimated cost savings to the state general fund for these rule changes for SFY 2012 has already been included in the fiscal impact statement and the Department's appropriations for SFY 2012 in the PARF under Docket No. 16-0310-1105. (Specifically, it is included in the $2,000,000 portion related to the budget for developmental disabilities services.)

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Paige Grooms at (208) 947-3364.

DATED this 1st day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, and, 56-250 through 56-257, Idaho Code; also House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

address below.

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

Rule changes are being made to align the rules with House Bill 260 passed by the 2011 Legislature. In Section 56-255(3)(f), Idaho Code, as amended, the Department is directed to respond to requests for budget modifications only when health and safety issues are identified and meet the criteria as defined in rule.

The Department is refining the developmental disabilities individual budget modification process, and related requirements and criteria. This will enable the Department to respond to requests for individual developmental disabilities budget modifications only when health and safety issues are identified.

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

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

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

Self-Directed Services come under Developmental Disabilities Waiver Services found in IDAPA 16.03.10. The total estimated cost savings to the state general fund for these rule changes for SFY 2012 has already been included in the fiscal impact statement and the Department's appropriations for SFY 2012 in the PARF under Docket No. 16-0310-1105. (Specifically, it is included in the $2,000,000 portion related to the budget for developmental disabilities services.)

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

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 Paige Grooms at (208) 947-3364.

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 August 24, 2011.

DATED this 13th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0313-1101

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, ~~*and*~~ Sections 56-250 through 257, and Sections 56-260 through 56-266, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the provision of consumer-directed services.
~~*(3-30-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. (3-30-07)

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. (3-30-07)

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. (3-30-07)

04. Consumer-Directed Community Supports (CDCS). For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). (7-1-11)

05. Family-Directed Community Supports (FDCS). A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

06. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: (3-29-10)

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (3-30-07)

b. Performing payroll services; and (3-30-07)

c. Handling billing and employment related documentation responsibilities. (3-30-07)

07. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the CDCS option. The fiscal employer agent (FEA) is selected by the participant. The duties of the FEA are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). (7-1-11)

08. Goods. Tangible products or merchandise that are authorized on the support and spending plan. (3-30-07)

09. Guiding Principles for the CDCS Option. Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (7-1-11)

a. Freedom for the participant to make choices and plan his own life; (3-30-07)

b. Authority for the participant to control resources allocated to him to acquire needed supports; (3-30-07)

c. Opportunity for the participant to choose his own supports; (3-30-07)

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-30-07)

e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (3-30-07)

10. Participant. A person eligible for and enrolled in the Consumer-Directed Services Programs. (7-1-11)

11. Readiness Review. A review conducted by the Department to ensure that each fiscal employer agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (3-29-10)

12. Self-Directed Community Supports (SDCS). A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

13. Support and Spending Plan. A support and spending plan is a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget. ~~(7-1-11)~~( )

14. Supports. Services provided for a participant, or a person who provides a support

service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (3-30-07)

15. Support Broker. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. (3-30-07)

16. Support Broker Services. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

17. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

18. Traditional Children's DD Waiver Services. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

19. Traditional Children's HCBS State Plan Option Services. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

20. Waiver Services. A collective term that refers to services provided under a Medicaid Waiver program. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

111. UNPAID COMMUNITY SUPPORTS AND SERVICES.
The Department requires that participants and their support broker identify and prioritize the use of any goods, services and supports available through an unpaid volunteer support or service, or those goods, services, and supports that can be provided by a natural support such as a family member, a friend, a neighbor or other volunteer. ( )

11~~1~~2. -- 119. (RESERVED)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: (3-30-07)

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option found in Section 010 of these rules. (7-1-11)

02. Person-Centered Planning. Participating in the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ~~(3-30-07)~~( )

03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and that are cost-effective when comparing them to reasonable alternatives, and including the details in the employment agreements. ~~(3-30-07)~~( )

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. (3-30-07)

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; and no employer-related claims will be filed against the Department. (3-30-07)

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. (3-30-07)

07. Time Sheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice. (3-29-10)

08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: (3-30-07)

a. Support broker application approval by the Department; (3-30-07)

b. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-30-07)

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. (3-30-07)

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: (3-30-07)

a. Participate in the person-centered planning process; (3-30-07)

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; ~~(3-30-07)~~( )

c. Assist the participant to monitor and review his budget; (3-30-07)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-30-07)

e. Participate with Department quality assurance measures, as requested; (3-30-07)

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; (3-30-07)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety; (7-1-11)

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected; and (7-1-11)

i. Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services. (7-1-11)

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: (3-30-07)

a. Assist the participant to develop and maintain a circle of support; (3-30-07)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-30-07)

c. Assist the participant to negotiate rates for paid community support workers; (3-30-07)

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; (3-30-07)

e. Assist the participant to monitor community supports; (3-30-07)

f. Assist the participant to resolve employment-related problems; and (3-30-07)

g. Assist the participant to identify and develop community resources to meet specific needs. (3-30-07)

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of his support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (3-30-07)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community. (3-30-07)

b. Paid or non-paid consumer-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-11)

i. Personal health and safety including quality of life preferences; (3-30-07)

ii. Securing and maintaining employment; (3-30-07)

iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (3-30-07)

iv. Learning and practicing ways to recognize and minimize interfering behaviors; and (3-30-07)

v. Learning new skills or improving existing ones to accomplish set goals. (3-30-07)

c. Support needs such as: (3-30-07)

i. Medical care and medicine; (3-30-07)

ii. Skilled care including therapies or nursing needs; (3-30-07)

iii. Community involvement; (3-30-07)

iv. Preferred living arrangements including possible roommate(s); and (3-30-07)

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-30-07)

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (3-30-07)

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; and (3-30-07)

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment. (3-30-07)

02. Support and Spending Plan Limitations. Support and spending plan limitations include: (3-30-07)

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these

traditional services and consumer-directed services at the same time, the participant, the support broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-11)

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional Medicaid services; (7-1-11)

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. ~~*Community supports that are not medically necessary or that do not minimize the participant's need for institutionalization must only be listed as non-paid supports. Additionally,* t~~The support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; ~~*(3-30-07)*~~( )

d. Support and spending plans that exceed the approved budget amount will not be authorized; and (3-30-07)

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

190. INDIVIDUALIZED BUDGET.
The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that he understands the budget figure is a fixed amount. (3-29-10)

01. Budget Amount Notification. The Department notifies each participant of his set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. ~~*The notification will include how the participant may request to appeal the set budget amount determined by the Department.*~~ ~~*(7-1-11)*~~( )

02. Annual Re-Evaluation of Adult Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's ~~*individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget*~~ condition that results in a need for services that meet medical necessity criteria,

and that is not reflected on the current inventory of individual needs. ~~(3-30-07)~~( )

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes *that may support placement in a different budget category as identified in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527.* ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.17 - RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Title 39, Chapter 46, and Sections 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

The Department eliminated the provider support services known as affiliation and implemented a selective contract for a waiver administrative function that will be referred to as Residential Habilitation Program Coordination for Certified Family Home (CFH) Providers.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 7, 2011, Idaho Administrative Bulletin, Vol. 11-9, pages 44 through 56**.**

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

The estimated fiscal impact of moving to a selective contract will be a total annual savings of $3.7 million of which $800,000 will be to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paige Grooms (208) 947-3364.

DATED this 17th day of November, 2011.

Tamara Prisock
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of these temporary rules is **August 5, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Title 39, Chapter 46, and Sections 56-202, 56-203(7), 56-203(9), 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking has been scheduled for:

MONDAY, SEPTEMBER 19, 2011, 10:00 A.M.

DHW Medicaid Office
3232 Elder
Conference Rm. D East and West
Boise, ID

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

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

Rule changes in this docket implement 2006 legislative intent regarding selective contracting, and legislation passed by the 2011 Legislature under House Bill 260. The Department has eliminated the provider support services known as affiliation and replaced it with a contract for a waiver administrative function that will be referred to as Residential Habilitation Program Coordination for Certified Family Home (CFH) Providers. These rules clarify the certification requirements for residential habilitation agency providers, the health and safety critical incident reporting requirements, and certification enforcement procedures.

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:

These rule changes protect the public health, safety, and welfare of Medicaid participants receiving residential habilitation agency services, and implement 2006 legislative intent regarding selective contracting and legislative changes adopted by the 2011 Legislature in House Bill 260, effective July 1, 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: None.

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

The estimated fiscal impact of moving to a selective contract will be a total annual savings of $3.7 million of which $800,000 will be to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation.

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 Paige Grooms (208) 947-3364.

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 September 28, 2011.

DATED this 9th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0417-1101

010. DEFINITIONS -- A THROUGH N.
For the purposes of these rules the following terms are used as defined below: (3-20-04)

01. Abuse. Any conduct of an employee*~~, affiliated residential habilitation provider~~* or contractor of an agency as a result of which a person suffers verbal aggression or humiliation, skin

bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive or death, or mental injury, and such condition or death is not justifiably explained, or where the history given concerning such condition or death, or the circumstances indicate that such condition or death, may not be the product of accidental occurrence under Section 39-5202, Idaho Code. ~~(3-20-04)~~( )

02. Administrator. The individual who is vested with primary responsibility for the direction and control of an agency, and who has power to legally bind the agency to contracts. (7-1-95)

03. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a person with developmental disabilities. A participant may act as his own advocate. (3-20-04)

04. Agency. Any business entity that directly provides ~~or affiliates with residential habilitation providers who provide~~ residential habilitation services under a Home and Community Based Services waiver for adults with developmental disabilities. ~~(7-1-95)~~( )

05. Appeal. A method to insure personal, civil and human rights by receiving, investigating, resolving, and documenting complaints related to the provision or termination of services of the residential habilitation services agency in accordance with IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-95)

06. Audit. A methodical examination and review. (7-1-95)

07. Board. The Idaho ~~State~~ Board of Health and Welfare. ~~(7-1-95)~~( )

08. Business Entity. A public or private organization owned or operated by one (1) or more persons. (7-1-95)

09. Certificate. A permit to operate a residential habilitation agency. (7-1-95)

10. Certifying Agency. ~~Regional u~~Units of the Department that conduct inspections and surveys and issue certificates based on the residential habilitation agency's compliance with this chapter. ~~(7-1-95)~~( )

11. Chemical Restraint. The use of any medication that results or is intended to result in the modification of behavior without an accompanying behavior management program. (7-1-95)

12. Complaint Investigation. An investigation of an agency to determine the validity of an allegation against it and to identify solutions to resolve conflicts between the complainant and the agency. (7-1-95)

13. Department. The Idaho Department of Health and Welfare. (7-1-95)

14. 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: (3-20-04)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other conditions found to be closely related to or similar to one of these impairments that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (7-1-95)

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 (7-1-95)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated. (7-1-95)

15. Deficiency. A determination of non-compliance with a specific rule or part of a rule. (7-1-95)

16. Director. Director of the Idaho Department of Health and Welfare or his designee. (7-1-95)

17. Exploitation. An action which may include the misuse of a vulnerable participant's funds, property, services, or resources by another person for profit or advantage. (3-20-04)

18. Full Certificate. A certificate issued by the Department to residential habilitation agencies complying with this chapter. (7-1-95)

19. Governing Authority. The designated person or persons who assume full responsibility for the conduct and operations of the residential habilitation services agency. (7-1-95)

20. Government Unit. The state, or any county, municipality, or other political subdivision, or any department, division, board or other agency thereof. (7-1-95)

21. Guardian. A legally-appointed person who has the care of the person or property of another, under Section 66-404, Idaho Code. (3-20-04)

22. Implementation Plan. Written documentation of participants' needs, desires, goals and measurable objectives, including documentation of planning, ongoing evaluation, data-based progress and participant satisfaction of the program developed, implemented, and provided by the agency specific to the plan of service. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

100. CERTIFICATION -- GENERAL REQUIREMENTS.

01. Certificate Required. After, July 1, 1995, no person, firm, partnership, association or corporation within the state and no state or local public agency may operate, establish, manage, conduct or maintain a residential habilitation agency without first obtaining a valid certificate issued by the certifying agency of the Department. No agency may provide services without a current certificate. ~~(3-20-04)~~( )

0~~1~~2. Application. An application for a certificate must be made to the ~~*regional office of the*~~ Department upon forms provided by ~~*it*~~ the Department and must contain ~~*such*~~ the required information ~~*as it reasonably requires*~~ under Section 101 of these rules, ~~*that must*~~ include~~e~~ing affirmative evidence of ability to comply with such reasonable standards and rules as are lawfully adopted by the Board. ~~(3-20-04)~~( )

~~***02. Issuance -- Full Certificate**. Upon receipt of an application for certification, the certifying agency must issue a certificate if the applicant meets the requirements established under this chapter. A certificate to provide residential habilitation services must be issued specifically for the persons or governmental units named in the application and is not transferable or assignable except with written approval of the certifying agency. Every agency must be designated by a distinctive name in applying for a certificate, and the name must not be changed without first notifying the certifying agency in writing at least thirty (30) days prior to the date the proposed change in name is to be effective. Certificates must be posted in a conspicuous place on the certified premises.* (3-20-04)~~

03. Denial. The certifying agency may deny any application when persuaded by evidence that such conditions exist as to endanger the health or safety of any participant. (3-20-04)

a. Additional causes for denial of certificate may include: (7-1-95)

i. The residential habilitation agency does not meet the needs of participants as written on the plans of service or Implementation Plans which will violate the participants' rights; or (3-20-04)

ii. The residential habilitation agency does not meet requirements for certification to the extent that it hinders its ability to provide quality services that comply with the rules for residential habilitation agencies; or (7-1-95)

iii. The residential habilitation agency has a history of repeat deficiencies. (7-1-95)

b. Before denial is final, the certifying agency must provide the opportunity for a hearing at which time the owner or sponsor of an agency may appear and show cause why the certificate should not be denied. A waiver of a specific rule or standard may be granted by the certifying agency in the event that good cause is shown for such a waiver and providing that said waiver does not endanger the health, safety or rights of any participant. The decision to grant a waiver must not be considered as precedent or be given any force or effect in any other proceeding. Said waiver may be renewed annually if sufficient written justification is presented to the certifying agency. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and

Declaratory Rulings." (3-20-04)

04. Revocation. The certifying agency may revoke any certificate when persuaded by the evidence that such conditions exist which endanger the health, safety, or welfare of any participant under the responsibility of the agency, or that the agency is not in substantial compliance with these rules. Additional causes for revocations of a certificate may include: (3-20-04)

a. The agency has a history of repeat deficiencies; ~~*or*~~ ~~*(7-1-95)*~~( )

b. The agency has been denied or has had revoked any certificate to operate a health or residential habilitation agency or has been convicted of operating any residential habilitation agency without a certificate or has been enjoined from operating such agency within two (2) years from the date of application; ~~*or*~~ ~~*(7-1-95)*~~( )

c. The agency lacks personnel sufficient in number or qualifications by training, experience, or judgment, to properly provide services to the proposed or actual numbers, and abilities and disabilities of participants; ~~*or*~~ ~~*(3-20-04)*~~( )

d. The agency has been guilty of fraud or deceit or misrepresentation in the preparation of the application or other documents required by the certifying agency; ~~*or*~~ ~~*(7-1-95)*~~( )

i. Has been guilty of fraud or deceit or misrepresentation or dishonesty associated with the operation of a certified residential habilitation agency; ~~*or*~~ ~~*(7-1-95)*~~( )

ii. Has been guilty of negligence or abuse or neglect or assault or battery while associated with the provision of services in its operation; ~~*or*~~ ~~*(7-1-95)*~~( )

e. The agency refuses to allow inspection of all residential habilitation records; ~~*or*~~ ~~*(7-1-95)*~~( )

f. The agency is not in substantial compliance with the provisions for services of participants' personal, civil or human rights outlined in Subsections 402.01.a. through 402.01.g.; or (3-20-04)

g. When the Department finds the public health, safety, or welfare imperatively require emergency action, a certificate may be summarily suspended pending proceedings for revocation or other action. (7-1-95)

~~***05. Emergency Powers of the Director**. In the event of an emergency endangering the life or safety of a participant receiving services from an agency, the Director may summarily suspend or revoke any residential habilitation certificate. As soon thereafter as practicable, the Director must provide an opportunity for a hearing.* *(3-20-04)***~~

~~***06. Injunction to Prevent Operation Without Certificate**. Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against any person or*~~

~~*governmental unit to restrain or prevent the establishment, conduct, management or operation of an agency without a certificate required under this chapter.* (7-1-95)~~

0~~7~~5. **Conformity**. Applicants for certification and certified residential habilitation agencies must conform to all applicable rules of the Department. (3-20-04)

0~~8~~6. **Inspection of Residential Habilitation Records**. The residential habilitation agency and all records required under these rules must be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection with or without prior notice. Refusal to allow such access must result in revocation of the residential habilitation agency's certificate. (3-20-04)

0~~9~~7. **Agency Provider Training**. The Department must assure that direct service providers of all residential habilitation service agencies receive ongoing training in the provision of services and supports to participants. (3-20-04)

Section 101 has been moved and renumbered to proposed Section 104

101. CERTIFICATION - ISSUANCE OF CERTIFICATES.
The Department will conduct an initial survey upon receipt of a completed application. ( )

01. Initial Certificate. When the Department determines that all application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. During this six (6) month period, the Department evaluates the agency's ongoing capability to provide services and to meet the standards of these rules. The Department will resurvey the agency prior to the end of the initial certification period. ( )

02. Renewal of Certificate. A certificate may be renewed by the Department when it determines the agency requesting recertification is in substantial compliance with the provisions of this chapter of rules. A certificate issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. ( )

03. Provisional Certificate. When a residential habilitation agency is found to be out of substantial compliance with these rules, but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period. A provisional certificate is issued contingent upon the correction of deficiencies in accordance to a plan developed by the agency and approved by the Department. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. If the Department determines the agency is in compliance, a certificate will be issued. If the agency is determined to be out of compliance, the certificate will be denied or revoked. ( )

04. Expiration of Certificate. An agency must request renewal of its certificate no less than ninety (90) days before the expiration of the certificate to ensure there is no lapse in

certification. After initial certification the Department may issue a certificate that is in effect for up to three (3) years based upon an agency's substantial compliance with this chapter of rules. ( )

102. CERTIFICATE NOT TRANSFERABLE.
The certificate is issued only to the agency named in the application, only for the period specified, and only to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. ( )

103. RETURN OF CERTIFICATE.
The certificate is the property of the state and must be returned to the state if it is revoked or suspended. ( )

10~~1~~4. CHANGE OF OWNERSHIP, ADMINISTRATOR OR LESSEE.

01. Notification to Department. Because certificates are not transferable from one (1) individual to another or from one (1) lessee to another or from one (1) location to another, when a change of ownership, lease or locations is contemplated, the agency must be recertified and implement the same procedure as an agency that has never been certified. When a change of a certified agency's ownership, administrator, lessee, title, or address occurs, the owner or designee must notify the Department in writing. (3-20-04)

02. New Application Required. A new application must be submitted in the instance of a change of ownership or lessee to the certifying agency at least sixty (60) days prior to the proposed date of change. (7-1-95)

03. Arms Length Agreement. Because of the inherently close relationship between the lessee and the lessor, an application for change of ownership of an agency that is being leased from a person who is in litigation for failure to meet certification standards or who has had his certificate revoked, must include evidence that there is a bona fide arms length agreement and relationship between the two (2) parties. (3-20-04)

10~~2~~5. -- 199. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

201. ADMINISTRATION.

01. Scope. Each residential habilitation agency must be organized and administered under one authority. If other than a single owner or partnership, the agency must have a governing board which assumes full legal responsibility for the overall conduct of the agency. (3-20-04)

02. Structure. The administrative responsibilities of the agency must be documented by means of a current organizational chart. (3-20-04)

03. Responsibilities. The governing authority must assume responsibility for: (3-20-04)

a. Adopting appropriate organizational bylaws and policies and procedures~~; and~~ ~~(7-1-95)~~( ); (7-1-95)

b. Appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written policies and procedures and applicable state and federal laws. The administrator must participate in deliberation of policy decisions concerning all services;~~ and~~ ~~(3-20-04)~~( ); (3-20-04)

c. Providing a continuing and annual program of overall agency evaluation;~~ and~~ ~~(7-1-95)~~( ); (7-1-95)

d. Assuring that appropriate training, space requirements, support services, and equipment for ~~staff or affiliated~~ residential habilitation ~~providers~~ agency staff are provided to carry out assigned responsibilities; and ~~(7-1-95)~~( ); (7-1-95)

e. Cooperating in participating in a system by which to coordinate with other service providers continuity of the delivery of residential habilitation services in the plan of service. (3-20-04)

202. ADMINISTRATOR.

An administrator is responsible and accountable for implementing the policies and procedures approved by the governing authority. (3-20-04)

01. Administrator Qualifications. Each agency must have a designated administrator who: (3-20-04)

a. Is at least twenty-one (21) years of age;~~ and~~ ~~(7-1-95)~~( ); (7-1-95)

b. Has satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-20-04)

c. Has a minimum of three (3) years of experience in service delivery to persons with developmental disabilities with at least one (1) year having been in an administrative role. (7-1-95)

02. Absences. The administrator must designate, in writing, a qualified person to perform the functions of the administrator to act in his absence. (3-20-04)

03. Responsibilities. The administrator, or his designee, must assume responsibility for: (3-20-04)

a. Developing and implementing written administrative policies and procedures which comply with applicable rules;~~ and~~ ~~(7-1-95)~~( ); (7-1-95)

b. Developing and implementing policies and procedures for agency staff and

~~affiliated residential habilitation~~ provider training, quality assurance, evaluation, and supervision; ~~and~~ ~~(7-1-95)~~( )

c. Conducting regular agency staff ~~and affiliated residential habilitation provider~~ meetings to review program and general participant needs and plan appropriate strategies for meeting those needs; ~~and~~ ~~(3-20-04)~~( )

d. Maintaining adequate financial accounting records according to government accepted accounting principles; ~~and~~ ~~(7-1-95)~~( )

e. Making all records available to the Department for review or audit; ~~and~~ ~~(7-1-95)~~( )

f. Developing and implementing a policy addressing safety measures to protect participants, and staff~~, and affiliated residential habilitation providers~~ as mandated by state and federal rules; and ~~(3-20-04)~~( )

g. Ensuring that agency personnel, ~~and affiliated providers~~ including those providing services under arrangement, practice within the bounds set forth by the applicable state licensure boards. ~~(7-1-95)~~( )

203. STAFF ~~AND AFFILIATED~~ RESIDENTIAL HABILITATION PROVIDER TRAINING.
Training must include orientation and ongoing training at a minimum as required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Training is to be a part of the orientation training and is required initially prior to accepting participants. All required training must be completed within six (6) months of employment ~~or affiliation~~ with a residential habilitation agency and documented in the employee ~~or affiliated~~ residential habilitation provider record. The agency must ensure that all employees~~, affiliated residential habilitation providers,~~ and contractors receive orientation training in the following areas: ~~(3-20-04)~~( )

01. Rights. Personal, civil, and human rights. (7-1-95)

02. Disabilities. Developmental disabilities commensurate with the skills of participants served. (3-20-04)

03. Understanding of Participants' Needs. A basic understanding of the needs, desires, goals and objectives of participants served. (3-20-04)

04. Supervision. Appropriate methods of supervision. (7-1-95)

05. Review of Services. A review of the specific services that the participant requires. (3-20-04)

06. First Aid and CPR. First aid, CPR, and universal precautions. (7-1-95)

(BREAK IN CONTINUITY OF SECTIONS)

301. PERSONNEL.

01. Policies. The agency is responsible for the recruitment, hiring, training, supervision, scheduling, and payroll for its employees, subcontractors or agents*~~; and training, supervision, and quality assurance for affiliated providers~~*. Written personnel policies must be on file and provided to employees *~~and affiliated residential habilitation providers~~* which describe the employee's *~~and affiliated residential habilitation provider's~~* rights, responsibilities, and agency's expectations. *~~(3-20-04)~~*( )

02. Work Schedules. Coverage is scheduled to assure compliance with the Individual Support and Implementation Plans and all work schedules must be kept in writing. The agency must specify provisions and procedures to assure back-up coverage for those work schedules. (3-20-04)

03. Personnel Records. A record for each employee *~~and affiliated residential habilitation provider~~* must be maintained from date of hire *~~or affiliation~~* for not less than one (1) year after the employee *~~or affiliated residential habilitation provider~~* is no longer employed by the agency, and must include at least the following: *~~(3-20-04)~~*( )

a. Name, current address and phone number of the employee; and (7-1-95)

b. Social Security number; and (7-1-95)

c. Education and experience; and (7-1-95)

d. Other qualifications (if licensed in Idaho, the original license number and the date the current registration expires, or if certificated, a copy of the certificate); and (7-1-95)

e. Date of employment *~~or affiliation~~*; and *~~(7-1-95)~~*( )

f. Position in the agency; and (7-1-95)

g. Date of termination of employment *~~or affiliation~~* and reason for termination, if applicable; and *~~(7-1-95)~~*( )

h. Documentation of initial orientation and required training; and (7-1-95)

i. Evidence of current CPR and First Aid certifications; and (7-1-95)

j. Verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-20-04)

k. Evidence that the employee *~~or affiliated residential habilitation provider~~* has received a job description and understands his duties. *~~(7-1-95)~~*( )

(BREAK IN CONTINUITY OF SECTIONS)

402. PARTICIPANT RIGHTS.

01. Responsibilities. Each residential habilitation agency must develop and implement a written policy outlining the personal, civil, and human rights of all participants. The policy protects and promotes the rights of each participant and includes the following: (3-20-04)

a. Inform each participant, or legal guardian, of the participant's rights and the rules of the agency; (3-20-04)

b. Allow and encourage individual participants to exercise their rights as participants of the agency, and as citizens of the United States, including the right to file complaints, and the right to due process; (3-20-04)

c. Inform each participant, or legal guardian, of the services to be received, the expected benefits and attendant risks of receiving those services, and of the right to refuse services, and alternative forms of services available; (3-20-04)

d. Provide each participant with the opportunity for personal privacy and ensure privacy during provision of services; (3-20-04)

e. Ensure that participants are not compelled to perform services for the agency, its employees, ~~*affiliated residential habilitation providers*~~ or contractors and ensure that participants who do work for the agency, its employees, ~~*affiliated residential habilitation providers*~~ or contractors, are compensated for their efforts at prevailing wages and commensurate with their abilities; ~~*(3-20-04)*~~( )

f. Ensure that participants have access to telephones, if living in a place other than their own home or the home of their family, with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their plans of service; and (3-20-04)

g. Ensure that participants have the opportunity to participate in social, religious, and community group activities. (3-20-04)

403. PARTICIPANT FINANCES.

When the residential habilitation agency or its employees~~, *affiliated residential habilitation providers*~~ or contractors are designated as the payee on behalf of the participants, the agency must establish and maintain an accounting system that: ~~*(3-20-04)*~~( )

01. Participant's Personal Finance Records. Assures a full and complete accounting of participants' personal funds entrusted to the agency, ~~*or*~~ its employees, ~~*affiliated residential habilitation providers*~~ or contractors on behalf of participants. Records of financial transactions must be sufficient to allow a thorough audit of the participant’s funds. ~~*(3-20-04)*~~( )

02. No Commingling of Funds. Precludes any commingling of participant funds with agency funds. (3-20-04)

03. Availability of Funds. Ensures that the participant's financial records must be available on request to the participant, participant's legal guardian or advocate. (3-20-04)

404. COMMUNICATION WITH PARTICIPANTS, PARENTS, LEGAL GUARDIANS, AND OTHERS.
The residential habilitation agency must promote participation of participants, legal guardians, relatives and friends in the process of providing services to a participant unless their participation is unobtainable or inappropriate as prescribed by the plan of service; and (3-20-04)

01. Reciprocal Communication. Answer communications from participant's families and friends promptly and appropriately; and (3-20-04)

02. Promotion of Visits and Activities. Promote frequent and informal opportunities for visits, trips or vacations; and (7-1-95)

03. Notification of Guardian of Participant's Condition. Notify ~~*promptly*~~ the participant's legal guardian within twenty-four (24) hours, if one exists, of any significant incidents, or changes in participant's condition including serious illness, accident, death, or abuse. ~~*(3-20-04)*~~( )

04. Notification to Department of a Participant's Condition. Through a Department approved process, the agency must notify the Department within twenty-four (24) hours of any significant incidents affecting health and safety or changes in a participant's condition, including serious illness, accident, death, emergency medical care, hospitalization, adult protective services contact and investigation, or if the participant is arrested, contacted by, or under investigation by law enforcement, or involved in any legal proceedings. The events and the agency response to the events must be documented in the participant file. ( )

405. TREATMENT OF PARTICIPANTS.
The residential habilitation agency must develop and implement written policies and procedures including definitions that prohibit mistreatment, neglect or abuse of the participant to include at least the following: (3-20-04)

01. Interventions. Positive behavior interventions must be used prior to and in conjunction with, the implementation of any restrictive intervention. (3-20-04)

02. No Abuse. Employees~~*, affiliated residential habilitation providers*~~ or contractors of the agency must not use physical, verbal, sexual, or psychological abuse or punishment. ~~*(3-20-04)*~~( )

03. No Punishment. Employees~~*, affiliated residential habilitation providers*~~ or contractors of the agency must not withhold food or hydration that contributes to a nutritionally adequate diet. ~~*(3-20-04)*~~( )

04. Reporting Violations. Any agency employee~~, affiliated residential habilitation provider~~ or contractor must report immediately report all allegations of mistreatment, abuse, neglect, injuries of unknown origin, or exploitation to the administrator and to adult protection workers and law enforcement officials, as required by law under Section 39-5202, Idaho Code, or to the Idaho Commission on Aging, IDAPA 15.01.03, "Rules Governing Ombudsman for the Elderly Program," or the designated state protection and advocacy system for persons with developmental disabilities when applicable. ~~(3-20-04)~~( )

05. Providing Evidence of Violation. Agencies must provide evidence that all alleged violations are thoroughly investigated and must protect the participant from the possibility of abuse while the investigation is in progress. (3-20-04)

06. Reporting Results of Investigations. Results of all investigations must be reported to the administrator or designee and to other officials in accordance with state law, and, if the alleged violation is verified, appropriate corrective action must be taken. (3-20-04)

07. Proper Treatment of Participants. Participants must be treated with dignity and respect and their personal choices and preferences are respected and honored whenever possible and consistent with their well being and their plan of service. (3-20-04)

08. Use of Restraint on Participants. No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of restraint on participants: (3-20-04)

a. Chemical restraint. Employees~~, affiliated residential habilitation providers~~ or contractors of the agency must not use chemical restraint unless authorized by an attending physician. ~~(3-20-04)~~( )

b. Mechanical restraint. (7-1-95)

i. Mechanical restraint may be used for medical purposes when authorized by an attending physician. (7-1-95)

ii. Mechanical restraint for non-medical purposes may be used only when a written behavior change plan is developed by the participant, his service coordinator, his team, and a QMRP or a behavior consultant/crisis management provider as qualified in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Informed participant consent is required. (3-20-04)

c. Physical restraint. (7-1-95)

i. Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented in the participant's record. (3-20-04)

ii. Physical restraint may be used in a non-emergency setting when a written behavior change plan is developed by the participant, his service coordinator, his team, and a QMRP or a behavior consultant/crisis management provider as qualified in IDAPA 16.0310, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Informed participant consent is required.

(3-20-04)

d. Seclusionary Time Out. Seclusionary time out may be used only when a written behavior change plan is developed by the participant, his service coordinator his team, and a QMRP or a behavior consultant/crisis management consultant as qualified in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Informed participant consent is required. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

501. ENFORCEMENT PROCESS.
The Department may impose a remedy or remedies when it determines a residential habilitation agency is not in compliance with these rules. ( )

01. Determination of Remedy. In determining which remedy or remedies to impose, the Department will consider the residential habilitation agency's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, the Department may impose any of the remedies in Subsection 501.02 of this rule, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. ( )

02. Enforcement Remedies. If the Department determines that a residential habilitation agency is out of compliance with these rules, it may impose any of the following remedies according to Section 501.01 of this rule. ( )

a. Require the residential habilitation agency to submit a plan of correction that must be approved in writing by the Department; ( )

b. Issue a provisional certificate with a specific date for correcting deficient practices; ( )

c. Ban enrollment of all participants with specified diagnoses; ( )

d. Ban any new enrollment of participants; ( )

e. Revoke the residential habilitation agency's certificate; or ( )

f. Summarily suspend the certificate and transfer participants. ( )

03. Immediate Jeopardy. If the Department finds a residential habilitation agency's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may summarily suspend the residential habilitation agency's certificate. ( )

04. No Immediate Jeopardy. If the Department finds that the residential habilitation agency's deficiency or deficiencies do not immediately jeopardize participant health or safety, the

Department may impose one (1) or more of the remedies specified in Subsections 501.02.a. through 501.02.e. of this rule. ( )

05. Repeat Deficiencies. If the Department finds a repeat deficiency in a residential habilitation agency, it may impose any of the remedies listed in Subsection 501.02 of this rule as warranted. The Department may monitor the residential habilitation agency on an "as needed" basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with requirements governing residential habilitation agencies and that it is likely to remain in compliance. ( )

06. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 501.02 of this rule if: ( )

a. The residential habilitation agency has not complied with any requirement in these rules within three (3) months after the date it was notified of its failure to comply with such requirement; or ( )

b. The residential habilitation agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys. ( )

502. REVOCATION OF CERTIFICATE.

01. Revocation of the Residential Habilitation Agency's Certificate. The Department may revoke a residential habilitation agency's certificate when persuaded by the preponderance of the evidence that the agency is not in substantial compliance with the requirements in this chapter of rules. ( )

02. Causes for Revocation of the Certificate. The Department may revoke any residential habilitation agency's certificate for any of the following causes: ( )

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; ( )

b. The agency is not in substantial compliance with these rules; ( )

c. When persuaded by preponderance of the evidence that conditions exist in the agency that endanger the health or safety of any participant; ( )

d. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person or persons supervising the provision of services in the agency. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ( )

e. The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants; ( )

f. The agency has failed to comply with any of the conditions of a provisional certificate; ( )

g. The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant; ( )

h. An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules; ( )

i. Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code; ( )

j. The agency lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the agency; ( )

k. The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Section 402 of these rules; ( )

l. The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the agency environment, agency records, or the participants. ( )

503. NOTICE OF ENFORCEMENT REMEDY.
The Department will notify the following of the imposition of any enforcement remedy on a residential habilitation agency: ( )

01. Notice to the Residential Habilitation Agency. The Department will notify the residential habilitation agency in writing, transmitted in a manner that will reasonably ensure timely receipt. ( )

02. Notice to Public. The Department will notify the public by sending the residential habilitation agency printed notices to post. The residential habilitation agency must post all the notices on their premises in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas. The notices must remain in place until all enforcement remedies have been officially removed by the Department. ( )

03. Notice to the Professional Licensing Boards. The Department will notify professional licensing boards, as appropriate. ( )

504. -- 509. (RESERVED)

510. EMERGENCY POWERS OF THE DIRECTOR.
In the event of an emergency endangering the life or safety of a participant receiving services from an agency, the Director may summarily suspend or revoke any residential habilitation certificate. As soon thereafter as practicable, the Director must provide an opportunity for a hearing. ( )

511. INJUNCTION TO PREVENT OPERATION WITHOUT CERTIFICATE.
Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against

any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of an agency without a certificate required under this chapter. ( )

5~~0~~12. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.01 - USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code; and 42 USC Section 5106a Child Abuse Prevention and Treatment and Adoption Reform (CAPTA).

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

The Department updated these rules to meet federal requirements for the Child Abuse Prevention and Treatment and Adoption Reform Act (CAPTA). The Department amended these rules for law enforcement investigations to be inclusive of child abuse, neglect, or abandonment. The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 7, 2011, Idaho Administrative Bulletin, Vol. 11-9, pages 57 through 59.

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

There is no anticipated fiscal impact due to this rule change.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tamara Prisock at (208) 334-5719.

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code; and 42 USC Section 5106a Child Abuse Prevention and Treatment and Adoption Reform (CAPTA).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 21, 2011.

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

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

The Department is updating these rules to meet federal requirements for the Child Abuse Prevention and Treatment and Adoption Reform Act (CAPTA). Current rule requires law enforcement to have a court order before the Department is allowed to release information to them. In Idaho, law enforcement, not the Department, has the ability to remove a child from his or her home when the child is in "imminent danger." The Department is amending these rules to assist in that process by allowing the Department to share information with law enforcement without a court order. This will alleviate delays in law enforcement's investigation of child abuse and neglect.

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

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

There is no anticipated fiscal impact due to this rule change.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to align these rules with federal statute (CAPTA).

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the proposed rule, contact Tamara Prisock at (208) 334-5719.

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

DATED this 8th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0501-1101

100. EXCEPTIONS TO REQUIREMENT FOR AUTHORIZATION.
Confidential information will be released without an authorization to individuals and entities in compliance with a court order, or if they are legally authorized to receive it. The following are exceptions to the requirement for an authorization: (3-20-04)

01. Advocates and Guardians. Federally-recognized protection and advocacy agencies or duly appointed guardians ad litem have access to an individual's file as necessary to perform their legal functions. Guardians ad litem have access to records as provided in Section 16-1623, Idaho Code, except for: (3-20-04)

a. Drug abuse and sickle cell anemia records maintained by the Veteran's Administration (VA), as required by 38 USC Section 7332; (3-20-04)

b. Claims under laws administered by the VA as required by 38 USC Section 3301; and (3-20-04)

c. Drug abuse prevention programs that receive federal assistance, as required by 42 USC Section 290ee - 3. (3-20-04)

02. Licensure. In compliance with Section 9-340C(9), Idaho Code, records will be released if they are part of an inquiry into an individual's or organization's fitness to be granted or retain a license, certificate, permit, privilege, commission or position. These records will otherwise be provided in redacted form as required by law or rule. (4-2-08)

03. Fugitives and Missing Persons. (3-20-04)

a. A state or local law enforcement officer may receive the current address of any cash assistance recipient who is a fugitive felon, in compliance with Section 56-221, Idaho Code. (3-20-04)

b. The following health information may be disclosed to a law enforcement officer for the purpose of identifying or locating a suspect, fugitive, material witness or missing person:

(3-20-04)

i. Name and address; (3-20-04)

ii. Date and place of birth; (3-20-04)

iii. Social security number; (3-20-04)

iv. Blood type and rh factor; (3-20-04)

v. Type of injury; (3-20-04)

vi. Date and time of treatment or death, if applicable; and (3-20-04)

vii. Distinguishing physical characteristics. (3-20-04)

c. DNA, dental records, or typing, samples or analysis of body fluids or tissue must not be disclosed. (3-20-04)

04. Duty to Warn or Report. Confidential information may be released without an authorization if necessary under a legal duty to warn or to report. (3-20-04)

05. Department Business, Monitoring and Legal Functions. Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors. Confidential information will be provided to counsel as needed to evaluate, prepare for and represent the Department in legal actions. (3-20-04)

06. Emergencies. Confidential information may be disclosed to qualified medical personnel to the extent necessary to respond to a medical emergency that requires immediate attention. (3-20-04)

07. Multidisciplinary Staffing. Confidential information may be disclosed to employees of the Department, law enforcement, and other appropriate individuals to participate in a multidisciplinary team evaluation of child protection cases under Section 16-1609A, Idaho Code, or interdisciplinary Department staffing of services for an individual. All individuals who participate in such staffing must not redisclose the information and must comply with any other pertinent statute, rule or regulation. (3-20-04)

08. Collaborative Staffing. Confidential information may be disclosed in staffing by the Department and other individuals or entities if all participants are involved with the same or similar populations and have an equal obligation or promise to maintain confidentiality. Disclosure of information in inter-agency staffing must be necessary to coordinate benefits or services, or to improve administration and management of the services. Confidential information may be disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the staffing. All individuals who participate in such staffing must not redisclose the

information except in compliance with any other pertinent statute, rule or regulation. (3-20-04)

09. Elected State Official. As provided by Section 16-1629(6), Idaho Code, any duly elected state official carrying out his official functions may have access to child protection records of the Department, and must not redisclose the information. (3-20-04)

10. Child Protection Agency. A legally mandated child protection agency may provide information necessary to investigate a report of known or suspected child abuse or neglect, or to treat a child and family who are the subjects of the record. (3-20-04)

11. Legally Authorized Agency. An agency will be provided appropriate information if the agency is legally responsible for or authorized to care for, treat or supervise a child who is the subject of the record. (3-20-04)

12. Informal Representatives. Informal representatives may be permitted to receive and deliver information on behalf of an individual, and may be given health information if the informal representative is directly involved with the individual's care. Confidential information may be withheld in whole or part if professional staff determines that disclosure is not in the best interest of the individual, based on the circumstances and their professional judgement. The Department will not disclose information that is prohibited from being disclosed by these rules or any other legal requirement. (3-20-04)

13. Law Enforcement. Any federal, state, or local law enforcement agency, or any agent of such agency, may be permitted access to information as needed in order to carry out its responsibilities under law to protect children from abuse, neglect, *or abandonment*. *( )*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.06 - CRIMINAL HISTORY AND BACKGROUND CHECKS

DOCKET NO. 16-0506-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. The effective date for this rule is **July 1, 2012**.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-203(2), 56-204A, 56-1004A, 39-1105, 39-1107, 39-1111, 39-1210(10), 39-1211(4), 39-3520 and 39-5604, Idaho Code.

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

Based on comments received during the public comment period, the Department is amending the Pending rule to include the following:

1. Add a "just cause" exemption to timelines to provide for the availability of employees who are not able to get fingerprinted within timelines specified in rule due to reasons beyond their control;

2. Clarify that there is no requirement for recurrent background checks if an applicant's continuous employment is verifiable; and

3. Formalize the requirement for employers to review background check results.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 7, 2011, Idaho Administrative Bulletin, Vol. 11-9, pages 60 through 69.

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

There is no anticipated fiscal impact due to these rule changes.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Fernando Castro, at (208) 332-7999.

DATED this 17th day of November, 2011.

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

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(2), 56-204A, 56-1004A, 39-1105, 39-1107, 39-1111, 39-1210(10), 39-1211(4), 39-3520 and 39-5604, Idaho Code.

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

Monday, September 19, 2011 2:00 p.m. (Local)	Wednesday, September 21, 2011 2:00 p.m. (Local)	Friday, September 23, 2011 1:00 p.m. (Local)
DHW Region II 1118 "F" Street, 2nd Floor Conf. Rm. Lewiston, ID	DHW Region V 1070 Hiline Rd. Suite 230 Pocatello, ID	DHW Region IV 1720 Westgate Dr. Suite A, Rm. 131 Boise, ID

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

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

These rules are being amended to clarify the process for receiving and accessing an applicant's criminal history check (CHC) records. Changes to these rules include the following:

1. **Definitions are being amended to clarify that an agency and employer are synonymous terms;**
2. **Citations to other Department rule chapters are being updated;**
3. **The application time frames are being clarified to help alleviate confusion by the applicant and employers on when an individual's application and fingerprints**

must be done to be in compliance with these rules;

4. **The list of disqualifying crimes resulting in unconditional denials are being updated for the different types of manslaughter in Section 18-4006, Idaho Code, and for any substantially conforming foreign criminal violations; and**
5. **Clarify that an individual sanctioned by Department programs will receive an unconditional denial.**

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

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

There is no anticipated fiscal impact due to these rule changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department is clarifying its rules.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Fernando Castro, at (208) 332-7999.

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

DATED this 8th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0506-1101

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter of rules, the following terms apply: ( )

01. Agency. An administrative subdivision of government or an establishment engaged in doing business for another entity. This term is synonymous with the term employer. ( )

0~~1~~2. Application. An individual's request for a criminal history and background check in which the individual discloses any convictions, pending charges, or child or adult protection findings, and authorizes the Department to obtain information from available databases and

sources relating to the individual. (3-26-08)

02~~2~~3. Clearance. A clearance issued by the Department once the criminal history and background check is completed and no disqualifying crimes or relevant records are found. (3-26-08)

03~~4~~4. Conviction. An individual is considered to have been convicted of a criminal offense as defined in Subsections 010.03.a. through 010.03.d. of this rule: (3-26-08)

a. When a judgment of conviction, or an adjudication, has been entered against the individual by any federal, state, military, or local court; (3-26-08)

b. When there has been a finding of guilt against the individual by any federal, state, military, or local court; (3-26-08)

c. When a plea of guilty or nolo contendere by the individual has been accepted by any federal, state, military, or local court; (3-26-08)

d. When the individual has entered into or participated in first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. This includes: (3-26-08)

i. When the individual has entered into participation in a drug court; or (3-26-08)

ii. When the individual has entered into participation in a mental health court. (3-26-08)

04~~5~~5. Criminal History and Background Check. A criminal history and background check is a fingerprint-based check of an individual's criminal record and other relevant records. (3-4-11)

05~~6~~6. Criminal History Unit. The Department's Unit responsible for processing fingerprint-based criminal history and background checks, conducting exemption reviews, and issuing clearances or denials according to these rules. (3-26-08)

06~~7~~7. Denial. A denial is issued by the Department when an individual has a relevant record or disqualifying crime. There are two (2) types of denials: (3-26-08)

a. Conditional Denial. A denial of an applicant because of a relevant record found in Section 230 of these rules. (3-26-08)

b. Unconditional Denial. A denial of an applicant because of a conviction for a disqualifying crime or a relevant record found in Sections 200 and 210 of these rules. (3-4-11)

07~~8~~8. Department. The Idaho Department of Health and Welfare or its designee. (3-26-08)

08~~9~~9. Disqualifying Crime. A disqualifying crime is a designated crime listed in

Section 210 of these rules that results in the unconditional denial of an applicant. (3-26-08)

10. **Employer**. An entity that hires people to work in exchange for compensation. This term is synonymous with the term agency. ( )

0911. **Exemption Review**. A review by the Department at the request of the applicant when a conditional denial has been issued. (3-26-08)

10**2**. **Federal Bureau of Investigation (FBI)**. The federal agency where fingerprint-based criminal history and background checks are processed. (3-26-08)

1**1**3. **Good Cause**. Substantial reason, one that affords a legal excuse. (3-4-11)

1**2**4. **Idaho State Police Bureau of Criminal Identification**. The state agency where fingerprint-based criminal history and background checks are processed. (3-26-08)

1**3**5. **Relevant Record**. A relevant record is a record that is ~~from~~ found in a search of criminal records or ~~from~~ registries checked by the Department as provided in Section 56-1004A, Idaho Code. ~~(3-4-11)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

060. EMPLOYER REGISTRATION.
Employers required to have Department criminal history and background checks on their employees, contractors, or staff must register with the Department and receive an employer identification number before criminal history and background check applications can be processed or accessed. ~~(3-26-08)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

100. INDIVIDUALS SUBJECT TO A CRIMINAL HISTORY AND BACKGROUND CHECK.
Individuals subject to a Department criminal history and background check are those persons or classes of individuals who are required by statute, or Department rules to complete a criminal history and background check. (3-4-11)

01. Adoptive Parent Applicants. Individuals who must comply with IDAPA 16.06.01, "Child and Family Services," and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." (3-4-11)

02. Alcohol or Substance Use Disorders Treatment Facilities and Programs. Individuals who must comply with IDAPA 16.07.20, "Alcohol and Substance Use Disorders

Treatment and Recovery Support Services Facilities and Programs," and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-4-11)

03. Certified Family Homes. Individuals who must comply with Section 39-3520, Idaho Code, IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

04. Children's Residential Care Facilities. Individuals who must comply with Section 39-1210, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." (3-4-11)

05. Children's Therapeutic Outdoor Programs. Individuals who must comply with Section 39-1208, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." (3-4-11)

06. Contracted Non-Emergency Medical Transportation Providers. Individuals who must comply with IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-4-11)

07. Designated Examiners and Designated Dispositioners. Individuals who must comply with IDAPA 16.07.39, "Appointment of Designated Examiners and Designated Dispositioners." (3-4-11)

08. Developmental Disabilities Agencies. Individuals who must comply with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

09. Emergency Medical Services (EMS). Individuals who must comply with IDAPA 16.02.03, "Rules Governing Emergency Medical Services," and IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ~~(3-4-11)~~( )

10. Home and Community-Based Services (HCBS). Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." ~~(3-4-11)~~( )

11. Home Health Agencies. Individuals who must comply with IDAPA 16.03.07, "Home Health Agencies." (3-4-11)

12. Idaho Child Care Program (ICCP). Individuals who must comply with IDAPA 16.06.12, "Rules Governing the Idaho Child Care Program." (3-4-11)

13. Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID). Individuals who must comply with IDAPA 16.03.11, "Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)." (3-4-11)

14. Licensed Foster Care. Individuals who must comply with Section 39-1211, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." (3-4-11)

15. Licensed Day Care. Individuals who must comply with Sections 39-1105, 39-

1113, and 39-1114, Idaho Code, and IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." (3-4-11)

16. Mental Health Clinics. Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-4-11)

17. Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units. Individuals who must comply with IDAPA 16.07.50, "Minimum Standards for Nonhospital, Medically-Monitored Detoxification/Mental Health Diversion Units." (3-4-11)

18. Personal Assistance Agencies. Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

19. Personal Care Service Providers. Individuals who must comply with Section 39-5604, Idaho Code, and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

20. Psychosocial Rehabilitation Providers. Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

21. Residential Care or Assisted Living Facilities in Idaho. Individuals who must comply with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (3-4-11)

22. Semi-Independent Group Residential Care Facilities for the Developmentally Disabled or Mentally Ill. Individuals who must comply with IDAPA 16.03.15, "Rules and Minimum Standards for Semi-Independent Group Residential Care Facilities for the Developmentally Disabled or Mentally Ill." (3-4-11)

23. Service Coordinators and Paraprofessional Providers. Individuals who must comply with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-4-11)

24. Skilled Nursing and Intermediate Care Facilities. Individuals who must comply with IDAPA 16.03.02, "Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities." (3-4-11)

25. Support Brokers and Community Support Workers. Individuals who must comply with IDAPA 16.03.13, "Consumer-Directed Services." (3-4-11)

101. DEPARTMENT INDIVIDUALS SUBJECT TO A CRIMINAL HISTORY AND BACKGROUND CHECK.
The following Department employees, ~~and~~ contractors, and volunteers are subject to criminal history and background checks. ~~(3-26-08)~~( )

01. Employees, Contractors, and Volunteers. Employees, contractors, and volunteers, providing direct care services or who have access to children or vulnerable adults as defined in Section 39-5302(10), Idaho Code. (3-29-10)

02. Employees of Bureau of Audits and Investigations. (3-26-08)

a. Fraud Investigators; (3-26-08)

b. Utilization Review Analysts; and (3-26-08)

c. Criminal History Staff. (3-26-08)

03. Employees at State Institutions. All employees of the following state funded institutions; (3-26-08)

a. Southwest Idaho Treatment Center, Nampa, Idaho; (3-26-08)

b. State Hospital North, Orofino, Idaho; and (3-26-08)

c. State Hospital South, Blackfoot, Idaho. (3-26-08)

04. Emergency Medical Services (EMS) Employees. EMS communication specialists and managers. (3-26-08)

05. Other Employees. Other Department employees as determined by the Director. (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

130. SUBMISSION OF APPLICATION.
An application for a criminal history and background check must be ~~*submitted*~~ *initiated on the Department's website* and received by the Department before a criminal history and background check can be ~~*initiated*~~ *processed*. ~~*Once the Department has received the notarized application and signed fingerprint card, t*~~The application is pending until the Department issues a clearance or denial, or the individual withdraws the application. ~~*An application must be submitted and received by the Department within twenty-one (21) days of it being completed and notarized.*~~ *The applicant has two options for processing the application:* ~~*(3-26-08)*~~*( )*

01. ~~*Submitting an*~~ *On-Line* Application ~~*On-Line*~~ *Process*. An *individual may submit the* application ~~*may be submitted*~~ through the Criminal History Unit's website at https://chu.dhw.idaho.gov. Individuals who submit their application through the website may schedule a fingerprinting appointment at a Department location. At the fingerprinting appointment, the Department will print the application and notarize the individual's signature. ~~*(3-26-08)*~~*( )*

02. ~~*Submitting an*~~ *Mail-in* Application ~~*by Mail*~~ *Process*. An individual may complete the application provided on the Department's website, print the application, have it notarized, and mail it to the Criminal History Unit with the signed fingerprint card and applicable fee. The application must be mailed to: ~~*the nearest fingerprint location as found on the Department's website or contact the Criminal History Unit as described in Section 005 of these rules*~~ Criminal History Unit, P. O. Drawer B, Lewiston, ID 83501. ~~*(3-26-08)*~~*( )*

131. -- 139. (RESERVED)

140. SUBMISSION OF FINGERPRINTS.
The Department's criminal history and background check is a fingerprint-based check. Ten (10) rolled fingerprints must be collected from the individual and submitted to the Department within the time frame for submitting applications as provided in Section 150 of these rules in order for a criminal history and background check request to be processed. The Department must obtain fingerprints electronically at one of its fingerprint locations, or the Department's fingerprint card must be used. A Department fingerprint card can be obtained by contacting the Criminal History Unit, described in Section 005 of these rules. ~~(3-26-08)~~( )

01. Department Fingerprinting Locations. A fingerprint appointment may be scheduled at designated Department locations where the Department will collect the individual's fingerprints. The locations are listed on the Department's website, or you may contact the Criminal History Unit as described in Section 005 of these rules. (3-26-08)

02. Submitting Fingerprints by Mail. An individual may elect to have fingerprints collected by a local law enforcement agency or by the applicant's employer. The fingerprint card must be *completed in accordance with the instructions provided*, signed, and mailed *along* with the completed notarized application and applicable fee to ~~*the nearest fingerprinting location*~~: Criminal History Unit, P. O. Drawer B, Lewiston, ID 83501. ~~(3-26-08)~~( )

141. -- 149. (RESERVED)

150. TIME FRAME FOR SUBMITTING APPLICATION AND FINGERPRINTS.
The completed notarized application and fingerprints must be submitted and received by the Department within twenty-one (21) days from the date of notarization. ( )

01. Availability to Provide Services. The applicant is not available to provide services or be licensed or certified when the notarized application is not received or the fingerprints have not been rolled ~~*for an on-line application*~~ within this time frame. ( )

02. Incomplete Application. The criminal history and background check is incomplete and will not be processed by the Department if this time frame is not met. ~~(3-26-08)~~( )

03. No Extension of Time Frame. The Department will not extend the twenty-one (21) day time frame, unless the applicant or employer provides just cause. An applicant for employment or employer can not submit a new application for the same purpose, or repeatedly re-sign and re-notarize the original application. ( )

(BREAK IN CONTINUITY OF SECTIONS)

190. CRIMINAL HISTORY AND BACKGROUND CHECK CLEARANCE.

A criminal history and background check clearance is issued by the Department once all relevant records and findings have been reviewed and the Department has cleared the applicant. The clearance will be published on the Department's website and the individual ~~or his employer~~ may print copies of the clearance. The employer must print out the clearance and maintain a copy readily available for inspection. ~~(3-26-08)~~( )

191. -- 199. (RESERVED)

200. UNCONDITIONAL DENIAL.
An individual who receives an unconditional denial is not available to provide services, have access, or to be licensed or certified by the Department. (3-26-08)

01. Reasons for an Unconditional Denial. Unconditional denials are issued for: (3-4-11)

a. Disqualifying crimes described in Section 210 of these rules; (3-4-11)

b. A relevant record on the Idaho Child Abuse Central Registry with a Level 1 or Level 2 finding; ~~or~~ ~~(3-4-11)~~( )

c. A relevant record on the Nurse Aide Registry.~~;~~ or ~~(3-4-11)~~( )

d. A relevant record on the state or federal Medicaid Exclusion List, described in Section 240 of these rules. ( )

02. Issuance of an Unconditional Denial. The Department will issue an unconditional denial within fourteen (14) days of completion of a criminal history and background check. (3-26-08)

03. Challenge of Department's Unconditional Denial. An individual has thirty (30) days from the date the unconditional denial is issued to challenge the Department's unconditional denial. The individual must submit the challenge in writing and provide court records or other information which demonstrates the Department's unconditional denial is incorrect. These documents must be filed with the Criminal History Unit described in Section 005 of these rules. (3-4-11)

a. If the individual challenges the Department's unconditional denial, the Department will review the court records, documents and other information filed by the individual. The Department will issue a decision within thirty (30) days of the receipt of the challenge. The Department's decision will be a final order under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

b. If the individual does not challenge the Department's unconditional denial within thirty (30) days, it becomes a final order of the Department under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152. (3-26-08)

04. No Exemption Review. No exemption review, as described in Section 250 of these rules, is allowed for an unconditional denial. (3-26-08)

05. Final Order. The Department's final order under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," Section 152, may be appealed in District Court. (3-26-08)

201. -- 209. (RESERVED)

210. DISQUALIFYING CRIMES RESULTING IN AN UNCONDITIONAL DENIAL. An individual is not available to provide direct care or services when the individual discloses or the criminal history and background check reveals a conviction for a disqualifying crime on his record as described in Subsections 210.01 and 210.02 of this rule. (3-26-08)

01. Disqualifying Crimes. The disqualifying crimes, described in Subsections 210.01.a. through 210.01.v. of ~~these~~ this rule~~s~~, or any substantially conforming foreign criminal violation, will result in an unconditional denial being issued. ~~(3-26-08)~~( )

a. Abuse, neglect, or exploitation of a vulnerable adult, as defined in Section 18-1505, Idaho Code; (3-26-08)

b. Aggravated, first-degree and second-degree arson, as defined in Sections 18-801 through 18-803, and 18-805, Idaho Code; (3-26-08)

c. Crimes against nature, as defined in Section 18-6605, Idaho Code; (3-26-08)

d. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; (3-26-08)

e. Incest, as defined in Section 18-6602, Idaho Code; (3-26-08)

f. Injury to a child, felony or misdemeanor, as defined in Section 18-1501, Idaho Code; (3-26-08)

g. Kidnapping, as defined in Sections 18-4501 through 18-4503, Idaho Code; (3-26-08)

h. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; (3-26-08)

i. Mayhem, as defined in Section 18-5001, Idaho Code; (3-26-08)

j. Manslaughter: ( )

i. Voluntary manslaughter, as defined in Section 18-4006(1) Idaho Code; ( )

ii. Involuntary manslaughter, as defined in Section 18-4006(2), Idaho Code; ( )

iii. Felony vehicular manslaughter, as defined in Section 18-4006(3)(a) and (b), Idaho Code; ( )

~~j~~k. Murder in any degree~~, voluntary manslaughter,~~ or assault~~, or battery~~ with intent to commit ~~a serious felony~~ murder, as defined in Sections 18-4001, 18-4003, ~~18-4006,~~ and 18-4015, Idaho Code; ~~(3-26-08)~~( )

~~k~~l. Poisoning, as defined in Sections 18-4014 and 18-5501, Idaho Code; (3-26-08)

~~l~~m. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; (3-26-08)

~~m~~n. Rape, as defined in Section 18-6101, Idaho Code; (3-26-08)

~~n~~o. Robbery, as defined in Section 18-6501, Idaho Code; (3-26-08)

~~o~~p. Felony stalking, as defined in Section 18-7905, Idaho Code; (3-26-08)

~~p~~q. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; (3-26-08)

~~q~~r. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; (3-26-08)

~~r~~s. Video voyeurism, as defined in Section 18-6609, Idaho Code; (3-26-08)

~~s~~t. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; (3-26-08)

~~t~~u. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; (3-26-08)

~~u~~v. Any felony punishable by death or life imprisonment; or (3-26-08)

~~v~~w. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. (3-29-10)

02. Disqualifying Five-Year Crimes. The Department will issue an unconditional denial for an individual who has been convicted of the following described crimes for five (5) years from the date of the conviction for the crimes listed in Subsections 210.02.a. through 210.02.~~h~~i. of this rule, or any substantially conforming foreign criminal violation: ~~(3-4-11)~~( )

a. Any felony not described in Subsection 210.01, of this rule; (3-4-11)

b. Misdemeanor forgery of and fraudulent use of a financial transaction card, as defined in Sections 18-3123 through 18-3128, Idaho Code; (3-4-11)

c. Misdemeanor forgery and counterfeiting, as defined in Sections 18-3601 through 18-3620, Idaho Code; (3-4-11)

d. Misdemeanor identity theft, as defined in Section 18-3126, Idaho Code; (3-4-11)

e. Misdemeanor insurance fraud, as defined in Sections 41-293 and 41-294, Idaho Code; (3-4-11)

f. Misdemeanor public assistance fraud, as defined in Sections 56-227 and 56-227A, Idaho Code; ~~or~~ ~~(3-4-11)~~( )

g. Stalking in the second degree, as defined in Section 18-7906, Idaho Code~~.~~; ~~(3-4-11)~~( )

h. Misdemeanor vehicular manslaughter, as defined in Section 18-4006(3)(c), Idaho Code; or ( )

~~h~~i. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying five (5) year crimes. (3-29-10)

03. Underlying Facts and Circumstances. The Department may consider the underlying facts and circumstances of felony or misdemeanor conduct including a guilty plea or admission in determining whether or not to issue a clearance, regardless of whether or not the individual received one (1) of the following: (3-26-08)

a. A withheld judgment; (3-26-08)

b. A dismissal, suspension, deferral, commutation, or a plea agreement where probation or restitution was or was not required; (3-26-08)

c. An order according to Section 19-2604, Idaho Code, or other equivalent state law; or (3-26-08)

d. A sealed record. (3-26-08)

(BREAK IN CONTINUITY OF SECTIONS)

240. MEDICAID EXCLUSION.
Individuals subject to these rules, who are excluded by the Office of the Inspector General, Department of Health and Human Services; or, are listed in the State of Idaho Medicaid Exclusion list, cannot provide Department funded services within the scope of these rules. At the expiration of the exclusion, the individual may reapply for a criminal history and background check. ~~(3-26-08)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

270. CRIMINAL OR RELEVANT RECORD - ACTION PENDING.

01. Notice of Inability to Proceed. When the applicant is identified as having a pending criminal action for a crime or relevant record that may disqualify him from receiving a clearance for the criminal history and background check, the Department may issue a notice of inability to proceed. ( )

02. Availability to Provide Services. The applicant is not available to provide service when a notice of inability to proceed or denial is issued by the Department. ( )

03. Reconsideration of Action Pending. In the case of an inability to proceed status, ~~T~~the applicant can submit documentation that the matter has been resolved to the Department for reconsideration. When the Department receives this documentation, the Department will notify the applicant of the reconsideration and issue a clearance or denial. ~~(3-26-08)~~( )

271. -- 299. (RESERVED)

300. UPDATING CRIMINAL HISTORY AND BACKGROUND CHECKS.
The employer is responsible for confirming that the applicant has completed a criminal history and background check as provided in Section 190 of these rules. ~~(3-26-08)~~( )

01. New Criminal History and Background Check. Any individual required to have a criminal history and background check under these rules must complete a new application, including fingerprints when: (3-26-08)

a. Accepting employment with a new employer; or (3-26-08)

b. Applying for licensure or certification with the Department; and (3-26-08)

c. His last Department criminal history and background check was completed more than three (3) years prior to his employment date or licensure application date. (3-26-08)

02. Use of Criminal History Check Within Three Years of Completion. Any employer may use a Department criminal history and background check clearance obtained under these rules if: (3-26-08)

a. The individual has received a Department's criminal history and background check clearance within three (3) years from the date of employment; and (3-26-08)

b. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and no disqualifying crimes are found. (3-26-08)

i. The action must be initiated by the employer within thirty (30) calendar days of obtaining access to the individual's criminal history and background check clearance issued by the Department; and ( )

ii. The employer must be able to provide proof of this action by maintaining a copy of

the records required in Subsections 300.02.a. and 300.02.b. of this rule. ( )

03. Employer Discretion. The new employer, at its discretion, may require an individual to complete a Department criminal history and background check at any time, even if the individual has received a criminal history and background check clearance within three (3) years. (3-26-08)

04. Department Discretion. The Department may, at its discretion or as provided in program rules, require a criminal history and background check of any individual covered under these rules at any time during the individual's employment, internship, or while volunteering. Any individual required to complete a criminal history and background check under Sections 100 and 101 of these rules, must be fingerprinted within fourteen (14) days from the date of notification by the Department that a new criminal history and background check is required. (3-26-08)

IDAPA 19 - IDAHO STATE BOARD OF DENTISTRY

19.01.01 - RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-902, 54-912(2)(4), and 54-924(8)(11)(12), Idaho Code.

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

The proposed rule change will correct an unintended negative impact to licensees regarding limitations on continuing education requirements; delete an advertising standard; distinguish incorporated documents as professional standards; correct conflict in rules regarding dental hygienist rules of practice; clarify board's role in approving dental assistant curriculum; general housekeeping changes.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011 Idaho Administrative Bulletin, Vol. 11-8, pages 153 through 162.

FISCAL IMPACT: There is no fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Miller, Executive Director, Idaho State Board of Dentistry, at (208) 334-2369.

DATED this 4th day of November, 2011.

Susan Miller, Executive Director
Idaho State Board of Dentistry
350 N. 9th St., Ste. M100
PO Box 83720
Boise, ID 83720-0021
Ph: (208) 334-2369
Fax: (208) 334-3247

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 54-902, 54-912(2)(4), and 54-924(8)(11)(12), Idaho Code.

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

Thursday, August 11, 2011 - 9:00 a.m.

Idaho State Board of Dentistry
350 N. 9th Suite M-100
Boise, ID 83702

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

The purpose of the proposed rule change is to:
1. **Correct an unintended negative impact to licensees regarding continuing education requirements;**
2. **Delete an advertising standard which was ruled unconstitutional;**
3. **Change reference to documents incorporated by reference as professional standards;**
4. **Correct potential conflict in rules regarding dental hygienist rules of practice;**
5. **Clarify Board's role in approving dental assistant curriculum; and**
6. **General housekeeping changes.**

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

No fees or charges are imposed by this rulemaking.

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

There is no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated

rulemaking was not conducted because the proposed revisions are non-controversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Miller, Idaho State Board of Dentistry, (208) 334-2369.

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 August 24, 2011.

DATED this first day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1101

004. INCORPORATION BY REFERENCE (RULE 4).
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents: (7-1-93)

01. ~~***Documents***~~ **Professional Standards**. ~~*(7-1-93)*~~( )

a. American Association of Oral and Maxillofacial Surgeons, Office Anesthesia Evaluation Manual, 7th Edition, 2006. (4-7-11)

b. American Dental Association, Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2007. (4-7-11)

c. American Dental Association, Guidelines for the Use of Sedation and General Anesthesia by Dentists, October 2007. (4-7-11)

d. American Dental Association Policy Statement: The Use of Sedation and General Anesthesia by Dentists, October 2007. (4-7-11)

e. Centers for Disease Control and Prevention, DHHS, Guidelines for Infection Control in Dental Health-Care Settings, 2003. (4-6-05)

f. American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), January 2009. (4-7-11)

g. American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code), June 2009. (4-7-11)

h. American Dental Hygienists' Association, Standards for Clinical Dental Hygiene Practice, March 10, 2008. (4-7-11)

i. American Association of Dental Boards, the Dental Patient Record, June 12, 2009. (4-7-11)

02. Availability. These documents are available for public review at the Idaho State Board of Dentistry, 350 North 9th Street, Suite M-100, Boise, Idaho 83720~~, or the Idaho State Law Library, Supreme Court Building, 451 W. State Street, Boise, Idaho 83720~~. ~~(3-15-02)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

031. DENTAL HYGIENISTS - PROHIBITED PRACTICE (RULE 31).
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, and these rules, a dental hygienist may not perform certain specified duties. (4-6-05)

01. Prohibited Duties. A dental hygienist is prohibited from performing the duties specified below: (4-6-05)

a. Definitive diagnosis and dental treatment planning; (4-6-05)

b. The operative preparation of teeth for the placement of restorative materials; (4-6-05)

c. The placement or carving of restorative materials unless authorized by issuance of an extended access restorative license endorsement; ~~(4-6-05)~~( )

d. Administration of any general anesthesia, minimal sedation, or moderate sedation; (4-7-11)

e. Final placement of any fixed or removable appliances; (4-6-05)

f. Final removal of any fixed appliance; (4-6-05)

g. Cutting procedures utilized in the preparation of the coronal or root portion of the tooth; (4-6-05)

h. Cutting procedures involving the supportive structures of the tooth; (4-6-05)

i. Placement of the final root canal filling; (4-6-05)

j. Final impressions of any tissue-bearing area, whether hard or soft tissue; (4-6-05)

k. Occlusal equilibration procedures for any prosthetic restoration, whether fixed or removable; (4-6-05)

l. Final placement of prefabricated or cast restorations or crowns; and (4-6-05)

m. Such other duties as specifically prohibited by the Board. (4-6-05)

032. -- 034. (RESERVED)

035. DENTAL ASSISTANTS - PRACTICE (RULE 35).

01. Direct Supervision. A dental assistant may perform specified activities under direct supervision as follows: (4-6-05)

a. Recording the oral cavity (existing restorations, missing and decayed teeth); (4-6-05)

b. Placement of topical anesthetic agents (prior to administration of a local anesthetic by a dentist or dental hygienist); (4-6-05)

c. Removal of excess bonding material from temporary and permanent restorations and orthodontic appliances (using hand instruments or contra-angle handpieces with disks or polishing wheels only); (4-6-05)

d. Expose and process radiographs; (4-6-05)

e. Take impressions for preparation of diagnostic models, bleach trays, fabrication of night guards, temporary appliances, temporary crowns or bridges; (4-6-05)

f. Record diagnostic bite registration; (4-6-05)

g. Record bite registration for fabrication of restorations; (4-6-05)

h. Provide patient education and instruction in oral hygiene and preventive services; (4-6-05)

i. Placement of cotton pellets and temporary restorative materials into endodontic access openings; (4-6-05)

j. Placement and removal of arch wire; (4-6-05)

k. Placement and removal of orthodontic separators; (4-6-05)

l. Placement and removal of ligature ties; (4-6-05)

m. Cutting arch wires; (4-6-05)

n. Removal of loose orthodontic brackets and bands to provide palliative treatment; (4-6-05)

o. Adjust arch wires; (4-6-05)

p. Etching of teeth prior to placement of restorative materials; (4-6-05)

q. Etching of enamel prior to placement of orthodontic brackets or appliances by a Dentist; (4-6-05)

r. Placement and removal of rubber dam; (4-6-05)

s. Placement and removal of matrices; (4-6-05)

t. Placement and removal of periodontal pack; (4-6-05)

u. Removal of sutures; (4-6-05)

v. Application of cavity liners and bases; (4-6-05)

w. Placement and removal of gingival retraction cord; (4-6-05)

x. Application of topical fluoride agents; and (4-6-05)

y. Performing such other duties as approved by the Board. (4-6-05)

02. Prohibited Duties. Subject to other applicable provisions of these rules and of the Act, dental assistants are hereby prohibited from performing any of the activities specified below: (7-1-93)

a. Definitive diagnosis and treatment planning. (4-6-05)

b. The placement or carving of permanent restorative materials in any manner. (7-1-93)

c. Any procedure using lasers. (4-6-05)

d. The administration of any general anesthetic, infiltration anesthetic or any injectable nerve block procedure. (4-6-05)

e. Any oral prophylaxis. Oral prophylaxis is defined as the removal of plaque, calculus, and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing. (7-1-93)

f. Any intra-oral procedure using a high-speed handpiece, except to the extent authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity. (4-6-05)

g. The following expanded functions, unless authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity and performed under direct supervision: (4-6-05)

i. Fabrication and placement of temporary crowns; (4-6-05)

ii. Perform the mechanical polishing of restorations; (7-1-93)

iii. Initiating, regulating and monitoring the administration of nitrous oxide/oxygen to a patient; (4-7-11)

iv. Application of pit and fissure sealants; (7-1-93)

v. Coronal polishing, unless authorized by a Certificate of Registration; this refers to the technique of removing soft substances from the teeth with pumice or other such abrasive substances with a rubber cup or brush. This in no way authorizes the mechanical removal of calculus nor is it to be considered a complete oral prophylaxis. This technique (coronal polishing) would be applicable only after examination by a dentist and removal of calculus by a dentist or dental hygienist. (7-1-93)

vi. Use of a high-speed handpiece restricted to the removal of orthodontic cement or resin. (4-6-05)

03. Expanded Functions Qualifications. A dental assistant may be considered Board qualified in expanded functions, authorizing the assistant to perform any or all of the expanded functions described in Subsection 035.02.g. upon satisfactory completion of the following requirements: (4-6-05)

a. Completion of Board-approved training in each of the expanded functions with verification of completion of the training to be provided to the Board upon request by means of a Certificate of Registration or other certificate evidencing completion of approved training. The required training shall include adequate training in the fundamentals of dental assisting, which may be evidenced by: (4-6-05)

i. Current certification by the Dental Assisting National Board; or (7-1-93)

ii. Successful completion of ~~*a*~~ Board-approved ~~*course*~~ curriculum in the fundamentals of dental assisting; or ~~*(3-18-99)*~~( )

iii. Successfully challenging the fundamentals course. (7-1-93)

b. Successful completion of a Board-approved competency examination in each of the expanded functions. There are no challenges for expanded functions. (3-18-99)

04. ~~*Course*~~ Curriculum Approval. Any school, college, institution, university or other teaching entity may apply to the Board to obtain approval of its course~~*s of instruction*~~ curriculum in expanded functions. Before approving such ~~*course*~~ curriculum, the Board may require satisfactory evidence of the content of the instruction, hours of instruction, content of examinations or faculty credentials. ~~*(3-18-99)*~~( )

05. Other Credentials. Assistants, who have completed courses or study programs in expanded functions that have not been previously approved by the Board, may submit evidence of the extent and nature of the training completed, and, if in the opinion of the Board the same is at

least equivalent to other Board-approved ~~*courses*~~ curriculum, and demonstrates the applicant's fitness and ability to perform the expanded functions, the Board may consider the assistant qualified to perform any expanded function(s). ~~*(3-18-99)*~~( )

036. -- 039. (RESERVED)

040. UNPROFESSIONAL CONDUCT (RULE 40).
A dentist or hygienist shall not engage in unprofessional conduct in the course of his practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, one (1) of the following: (7-1-93)

01. Fraud. Obtaining fees by fraud or misrepresentation, or over-treatment either directly or through an insurance carrier. (7-1-93)

02. Unlicensed Practice. Employing directly or indirectly any suspended or unlicensed dentist or dental hygienist to practice dentistry or dental hygiene as defined in Title 54, Chapter 9, Idaho Code. (7-1-93)

03. Unlawful Practice. Aiding or abetting licensed persons to practice dental hygiene or dentistry unlawfully. (7-1-93)

04. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate with him in the practice of dentistry, unless: (7-1-93)

a. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; (7-1-93)

b. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. (7-1-93)

05. Controlled Substances. Prescribing or administering controlled substances not reasonably necessary for, or within the scope of, providing dental services for a patient. In prescribing or administering controlled substances, a dentist shall exercise reasonable and ordinary care and diligence and exert his best judgment in the treatment of his patient as dentists in good standing in the state of Idaho, in the same general line of practice, ordinarily exercised in like cases. A dentist may not prescribe controlled substances for or administer controlled substances to himself. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing controlled substances. (3-18-99)

06. Harassment. The use of threats or harassment to delay or obstruct any person in providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of Title 54, Chapter 9, Idaho Code, or the Board's Rules, or to aid in such compliance. (7-1-93)

07. Discipline in Other States. Conduct himself in such manner as results in a suspension, revocation or other disciplinary proceedings with respect to his license in another

state. (3-18-99)

08. Altering Records. Alter a patient's record with intent to deceive. (7-1-93)

09. Office Conditions. Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession in the state of Idaho and current recommendations of the American Dental Association and the Centers for Disease Control as referred to in Section 004. (7-1-93)

10. Abandonment of Patients. Abandonment of patients by licensees before the completion of a phase of treatment, as such phase of treatment is contemplated by the customary practice and standards of the dental profession in the state of Idaho, without first advising the patient of such abandonment and of further treatment that is necessary. (7-1-93)

11. Use of Intoxicants. Practicing dentistry or dental hygiene while under the influence of an intoxicant or controlled substance where the same impairs the dentist's or hygienist's ability to practice dentistry or hygiene with reasonable and ordinary care. (7-1-93)

12. Mental or Physical Illness. Continued practice of dentistry or dental hygiene in the case of inability of the licensee to practice with reasonable and ordinary care by reason of one (1) or more of the following: (7-1-93)

a. Mental illness; (7-1-93)

b. Physical illness, including but not limited to, deterioration through the aging process, or loss of motor skill. (7-1-93)

13. Consent. Revealing personally identifiable facts, data or information obtained in a professional capacity without prior consent of the patient, except as authorized or required by law. (3-18-99)

14. Scope of Practice. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities that the licensee knows or has reason to know that he or she is not competent to perform. (3-18-99)

15. Delegating Duties. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows, or with the exercise of reasonable care and control should know, that such a person is not qualified by training or by licensure to perform them. (3-18-99)

16. Unauthorized Treatment. Performing professional services that have not been authorized by the patient or his legal representative. (3-18-99)

17. Supervision. Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional. (7-1-93)

18. Legal Compliance. Failure to comply with any provisions of federal, state or local laws, statutes, rules, and regulations governing or affecting the practice of dentistry or dental

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

19. Exploiting Patients. Exercising undue influence on a patient in such manner as to exploit a patient for the financial or personal gain of a practitioner or of a third party. (7-1-93)

20. Misrepresentation. Willful misrepresentation of the benefits or effectiveness of dental services. (7-1-93)

21. Disclosure. Failure to advise patients or their representatives in understandable terms of the treatment to be rendered, alternatives, and disclosure of reasonably anticipated fees relative to the treatment proposed. (3-18-99)

22. Sexual Misconduct. Making suggestive, sexual or improper advances toward a patient or committing any lewd or lascivious act upon or with a patient. (7-1-93)

23. Patient Management. Use of unreasonable and/or damaging force to manage patients, including but not limited to hitting, slapping or physical restraints. (7-1-93)

24. ~~*American Dental Association*~~ Compliance With Dentist Professional Standards. Failure by a dentist to comply with ~~*the American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code)*~~ professional standards applicable to the practice of dentistry, as incorporated by reference in this chapter.
~~*(3-20-04)*~~( )

25. ~~*American Dental Hygienists' Association*~~ Compliance With Dental Hygienist Professional Standards. Failure by a dental hygienist to comply with ~~*the American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code)*~~ professional standards applicable to the practice of dental hygiene, as incorporated by reference in this chapter.
~~*(4-6-05)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

046. ADVERTISING (RULE 46).
Dentists and dental hygienists licensed to practice in Idaho may advertise in any medium or by other form of public communication so long as any such advertising is not false, deceptive, misleading or not readily subject to verification. In addition to any other applicable grounds, a violation of this advertising rule shall constitute and be considered as unethical and unprofessional conduct pursuant to the Idaho Dental Practice Act and this chapter. (3-20-04)

01. General Advertising Provisions. (3-20-04)

a. "Advertisement" shall mean any public communication, made in any form or manner whatsoever, about a licensee's professional services or qualifications for the purpose of soliciting business. "Advertising" or "advertise" shall mean holding out, broadcasting, mailing, publishing, transmitting, announcing, distributing or otherwise disseminating any advertisement,

whether directly or indirectly through the efforts of another person or entity. Any sign soliciting business, whether at the location of the dental practice or otherwise, shall be considered as an advertisement. A licensee who engages or authorizes another person or entity to advertise for or on the licensee's behalf is responsible for the content of the advertisement unless the licensee can prove that the content of the advertisement was contrary to the licensee's specific directions. (3-20-04)

b. If the form or manner of advertising consists of or contains verbal communication to the public by television, radio, or other means, the advertisement shall be prerecorded and approved for broadcast by the licensee and a recording of the actual advertisement shall be retained by the licensee for a period of two (2) years. Upon receipt of a written request from the Board, a licensee shall provide any such recorded advertisement to the Board within five (5) working days. (3-20-04)

c. Any advertisement made under or by means of a fictitious or assumed business name or in the name of a professional service corporation shall be the responsibility of all licensees who are owners of the business or corporation. (3-20-04)

02. Prohibited Advertising. A licensee shall not advertise in any form or manner which is false, misleading or deceptive to the public or which is not readily susceptible to verification. False, misleading or deceptive advertising or advertising that is not readily susceptible to verification includes, but is not limited to, advertising that: (3-20-04)

a. Makes a material misrepresentation of fact or omits a material fact; (3-20-04)

b. Makes a representation likely to create an unjustified expectation about the results of a dental procedure; (3-20-04)

c. Compares a licensee's services with another licensee's services unless the comparison can be factually substantiated; (3-20-04)

d. Makes a representation that is misleading as to the credentials, education, or the licensing status of a licensee; (3-20-04)

e. Represents that the benefits of a dental insurance plan will be accepted as full payment when deductibles or copayments are required; (3-20-04)

~~***f.*** *Makes a representation that is intended to take advantage of the fears or emotions of a particularly susceptible type of patient; and* *(3-20-04)*~~

~~***g***~~**f.** Refers to benefits of dental procedures or products that involve significant risks without including realistic assessments of the safety and efficacy of those procedures or products. (3-20-04)

03. Specialty Advertising. The Board recognizes and licenses the following specialty areas of dental practice: Dental Public Health; Endodontics; Oral and Maxillofacial Pathology; Oral and Maxillofacial Radiology; Oral and Maxillofacial Surgery; Orthodontics; Pediatric Dentistry; Periodontics; and Prosthodontics. The specialty advertising rules are intended to allow

the public to be informed about recognized dental specialities and specialization competencies of licensees and to require appropriate disclosures to avoid misperceptions on the part of the public. (4-6-05)

a. An advertisement shall not state that a licensee is a specialist, or specializes in a recognized specialty area of dental practice, or limits his practice to any recognized specialty area of dental practice unless the licensee has been issued a license ~~*or certification*~~ in that specialty area of dental practice by the Board. Use of words or terms in advertisements such as "Endodontist," "Pedodontist," "Pediatric Dentist," "Periodontist," "Prosthodontist," "Orthodontist," "Oral and Maxillofacial Pathologist," "Oral Pathologist," "Oral and Maxillofacial Radiologist," "Oral Radiologist," "Oral and Maxillofacial Surgeon," "Oral Surgeon," "Specialist," "Board Certified," "Diplomate," "Practice Limited To," and "Limited To Specialty Of" shall be prima facie evidence that the licensee is announcing or holding himself out to the public as a specialist or that the licensee specializes in a recognized area of dental practice. ~~*(4-6-05)*~~( )

b. A licensee who has not been licensed ~~*or certified*~~ by the Board in a recognized specialty area of dental practice may advertise as being qualified in a recognized specialty area of dental practice so long as each such advertisement, regardless of form, contains a prominent disclaimer that the licensee is "licensed as a general dentist" or that the specialty services "will be provided by a general dentist." Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area. ~~*(3-20-04)*~~( )

c. A licensee shall not advertise as being a specialist in or as specializing in any area of dental practice which is not a Board recognized and licensed specialty area unless the advertisement, regardless of form, contains a prominent disclaimer that the advertised area of dental practice is not recognized as a specialty area of dental practice by the Idaho Board of Dentistry. Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area. (3-20-04)

047. -- 049. (RESERVED)

050. CONTINUING EDUCATION FOR DENTISTS (RULE 50).
Effective October 1994, renewal of any active dental license will require evidence of completion of continuing education or volunteer dental practice that meets the following requirements. (4-6-05)

01. Requirements: (3-18-99)

a. All active dentists must hold a current CPR card. (7-1-93)

b. All active dentists shall acquire thirty (30) credits of verifiable continuing education in each biennial renewal period. One (1) credit is defined as one (1) hour of instruction. ~~*(3-30-07)*~~( )

c. Continuing education must be oral health/health-related for the professional development of a dentist. The thirty (30) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, and viewing of videotape or listening to

other media devoted to dental education. ~~Not more than eight (8) of the required credits shall be obtained through self-study.~~ ~~(3-29-10)~~( )

d. A dentist holding an active status license issued by the Board shall be allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental practice performed during the biennial renewal period up to a maximum of ten (10) credits. (3-30-07)

e. Any person who becomes licensed as an active dentist during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of continuing education credits as specified by the Board. (3-30-07)

02. Documentation. In conjunction with license renewal, the dentist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental practice performed and certify that the minimum requirements were completed in the biennial renewal period. (3-30-07)

051. CONTINUING EDUCATION FOR DENTAL HYGIENISTS (RULE 51).
Effective April 1994, renewal of any active dental hygiene license or dental hygiene license endorsement will require evidence of completion of continuing education or volunteer dental hygiene practice that meets the following requirements. (4-6-05)

01. Requirements for Renewal of an Active Status Dental Hygiene License: (4-6-05)

a. All active dental hygienists must hold a current CPR card. (6-2-92)

b. All active dental hygienists shall acquire twenty-four (24) credits of verifiable continuing education in each biennial renewal period. One (1) credit is defined as one (1) hour of instruction. ~~(3-30-07)~~( )

c. Continuing education must be oral health/health-related education for the professional development of a dental hygienist. The twenty-four (24) credits shall be obtained through continuing education courses, correspondence courses, college credit courses, viewing of videotape or listening to other media devoted to dental hygiene education. ~~Not more than six (6) of the required credits shall be obtained through self-study.~~ ~~(3-29-10)~~( )

d. A dental hygienist holding an active status license issued by the Board shall be allowed one (1) credit of continuing education for every two (2) hours of verified volunteer dental hygiene practice performed during the biennial renewal period up to a maximum of ten (10) credits. (3-30-07)

e. Any person who becomes licensed as an active dental hygienist during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of continuing education credits as specified by the Board. (3-30-07)

02. Requirements for Renewal of an Extended Access Dental Hygiene License Endorsement. In addition to any other continuing education requirements for renewal of a dental hygiene license, a person granted an extended access dental hygiene license endorsement shall

complete twelve (12) credits of verifiable continuing education in each biennial renewal period in the specific practice areas of medical emergencies, local anesthesia, oral pathology, care and treatment of geriatric, medically compromised or disabled patients and treatment of children. Any person who is issued an extended access dental hygiene license endorsement during any biennial renewal period shall be required at the time of the next successive license renewal to report a prorated amount of those continuing education credits required under this section as specified by the Board. *(3-30-07)*( )

03. Documentation. In conjunction with license and endorsement renewal, the dental hygienist shall provide a list of continuing education credits obtained and verification of hours of volunteer dental hygiene practice performed and certify that the minimum requirements were completed in the biennial renewal period. (3-30-07)

IDAPA 19 - IDAHO STATE BOARD OF DENTISTRY

19.01.01 - RULES OF THE STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-1102

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-902, 54-912(2)(4), and 54-924(8)(11)(12), Idaho Code.

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

The proposed rule change will authorize a dentist who holds a moderate enteral sedation permit to administer enteral sedation to patients who are sixteen (16) years of age and older and one hundred (100) pounds and over.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011 Idaho Administrative Bulletin, Vol. 11-10, pages 427 through 429.

FISCAL IMPACT: There is no fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Miller, Executive Director, Idaho State Board of Dentistry, at (208) 334-2369.

DATED this 4th day of November, 2011.

Susan Miller, Executive Director
Idaho State Board of Dentistry
350 N. 9th St., Ste. M100
PO Box 83720
Boise, ID 83720-0021
Ph: (208) 334-2369
Fax: (208) 334-3247

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 54-902, 54-912(2)(4), and 54-924(8)(11)(12), Idaho Code.

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

Wednesday, October 19, 2011 - 10:00 a.m.

Idaho State Board of Dentistry
350 N. 9th Suite M-100
Boise, ID 83702

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

Board of Dentistry rules regarding moderate enteral sedation currently limits a qualified dentist from administering moderate enteral sedation to patients under eighteen (18) years of age. The Board proposes to change the rule to allow qualified dentists to administer moderate enteral sedation to patients who are sixteen (16) years of age and older and one hundred (100) pounds and over. These limitations are considered generally accepted safe practice standards.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the proposed revisions are non-controversial.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Miller, Idaho State Board of Dentistry, (208) 334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 15th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1102

060. MODERATE SEDATION (RULE 60).
Dentists licensed in the state of Idaho cannot administer moderate sedation in the practice of dentistry unless they have obtained the proper moderate sedation permit from the Idaho State Board of Dentistry. A moderate sedation permit may be either enteral or parenteral. A moderate enteral sedation permit authorizes dentists to administer moderate sedation by either enteral or combination inhalation-enteral routes of administration. A moderate parenteral sedation permit authorizes a dentist to administer moderate sedation by any route of administration. A dentist shall not administer moderate sedation to children under ~~*eighteen*~~ sixteen (1~~8~~6) years of age and one hundred (100) pounds unless they have qualified for and been issued a moderate parenteral sedation permit. ~~*(4-7-11)*~~( )

01. Requirements for a Moderate Enteral Sedation Permit. To qualify for a moderate enteral sedation permit, a dentist applying for a permit shall provide proof that the dentist has completed training in the administration of moderate sedation to a level consistent with that prescribed in the American Dental Association's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," as incorporated in Section 004 in these rules. The five (5) year requirement regarding the required training for a moderate enteral sedation permit shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the application date. To obtain a moderate enteral sedation permit, a dentist must provide certification of the following: (4-7-11)

a. Completion of an American Dental Association accredited or Board of Dentistry approved post-doctoral training program within five (5) years of the date of application for a moderate enteral sedation permit that included documented training of a minimum of twenty-four (24) hours of instruction plus management of at least ten (10) adult case experiences by the enteral and/or enteral-nitrous oxide/oxygen route. These ten (10) cases must include at least three live clinical dental experiences managed by participants in groups no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning a patient from deep to moderate sedation; and (4-7-11)

b. Proof of current certification of Advanced Cardiac Life Support or its equivalent. (4-7-11)

02. Requirements for a Moderate Parenteral Sedation Permit. To qualify for a moderate parenteral sedation permit, a dentist applying for a permit shall provide proof that the dentist has completed training in the administration of moderate parenteral sedation as prescribed in the American Dental Association's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," as incorporated in Section 004 of these rules within the five (5) year period immediately prior to the date of application for a moderate parenteral sedation permit. The five (5) year requirement shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the date of application. The training program shall: (4-7-11)

a. Be sponsored by or affiliated with a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or a teaching hospital or facility approved by the Board of Dentistry; and (4-5-00)

b. Consist of a minimum of sixty (60) hours of instruction, plus management of at least twenty (20) patients by the intravenous route; and (4-7-11)

c. Include the issuance of a certificate of successful completion that indicates the type, number of hours, and length of training received. (3-18-99)

d. In addition, the dentist must maintain current certification in Advanced Cardiac Life Support or its equivalent. (4-7-11)

03. General Requirements for Moderate Enteral and Moderate Parenteral Sedation Permits. (4-7-11)

a. Facility Requirements. The dentist must have a properly equipped facility for the administration of moderate sedation. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue. Evaluators appointed by the Idaho State Board of Dentistry will periodically assess the adequacy of the facility and competence of the anesthesia team. The Board adopts the standards incorporated by reference in Section 004.01.c. and Section 004.01.d. of these rules as set forth by the American Dental Association. (4-7-11)

b. Personnel. For moderate sedation, the minimum number of personnel shall be two (2) including: (4-7-11)

i. The operator; and (10-1-87)

ii. An assistant currently certified in Basic Life Support for Healthcare Providers. (4-7-11)

iii. Auxiliary personnel must have documented training in basic life support for healthcare providers, shall have specific assignments, and shall have current knowledge of the emergency cart inventory. The practitioner and all office personnel must participate in documented periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction. (4-7-11)

c. Permit Renewal. Renewal of the permit will be required every five (5) years. Proof of a minimum of twenty-five (25) credit hours continuing education in moderate sedation which may include training in medical/office emergencies will be required to renew a permit. A fee shall be assessed to cover administrative costs. (4-7-11)

d. Reinstatement. A dentist may make application for the reinstatement of an expired or surrendered permit issued by the Board under this rule within five (5) years of the date of the permit's expiration or surrender. Applicants for reinstatement of a permit shall satisfy the facility and personnel requirements of this rule and shall be required to verify that they have obtained an average of five (5) credit hours of continuing education in moderate sedation for each year subsequent to the date upon which the permit expired or was surrendered. A fee for reinstatement shall be assessed to cover administrative costs. (4-7-11)

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 PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404(11), Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the June 1, 2011 Idaho Administrative Bulletin, Vol. 11-6, pages 35 through 37.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: None.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, M.A.Ed., R.N., Executive Director, at (208) 577-2482.

DATED this 24th day of June, 2011.

Sandra Evans, M.A.Ed., R.N., Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: (208) 577-2482
Fax: (208) 334-3262

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404(11), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 15, 2011.

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

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

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. The rulemaking removes this impediment by authorizing the Board to measure beginning level competency through an alternative process.

The temporary rulemaking was approved by the 2011 Legislature. The complete text of the temporary rule was published in the December 1, 2010 Idaho Administrative Bulletin, Vol. 10-12, pages 169 and 170.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: None.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because there was a need to do temporary rulemaking and the rulemaking confers a benefit on applicants and the general public.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, M.A.Ed., R.N., Executive Director, at (208) 577-2482.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 22, 2011.

DATED this 10th day of May, 2011.

THE FOLLOWING IS THE TEXT OF 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)*~~( )

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)*~~( )

d. Having another person appear in his place for ~~*the*~~ any certification examination required by the Board; or ~~*(3-26-08)*~~( )

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)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.10.01 - RULES OF THE STATE BOARD OF OPTOMETRY

DOCKET NO. 24-1001-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1509, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011 Idaho Administrative Bulletin, Vol. 11-8, pages 212 through 214.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1509, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

The 2011 Legislature passed Senate Bill 1137 which eliminated the ballot process for appointment of board members. This rule change will eliminate the ballot process language in the rule to be consistent with the current statute.

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

The 2011 Legislature passed Senate Bill 1137 which eliminated the ballot process for appointment of board members. This rule change will eliminate the ballot process language in the rule to be consistent with the current statute.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the change is needed to be consistent with current statute.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into

this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 7th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1001-1101

~~***011. -- 099. (RESERVED)***~~

~~***100. NOMINATIONS OF BOARD MEMBERS (RULE 100).***~~

~~***01. Districts****. In order to establish the districts from which a vacancy in the membership of the Board of Optometry shall be filled, the state is divided into the following three (3) districts by counties as follows:*~~

~~***a.*** North District.~~

~~***North District***~~	
~~Lemhi~~	~~Latah~~
~~Boundary~~	~~Clearwater~~
~~Bonner~~	~~Nez Perce~~
~~Kootenai~~	~~Valley~~
~~Shoshone~~	~~Idaho~~
~~Benewah~~	~~Adams~~
~~Lewis~~	~~Custer~~
~~Washington~~	~~Butte~~
~~Payette~~	~~Jefferson~~
~~Boise~~	~~Madison~~
~~Teton~~	~~Clark~~
~~Blaine~~	~~Fremont~~

~~(7-1-97)~~

~~**b.** *Southwest District.*~~

~~Southwest District~~	
~~Ada~~	~~Gem~~
~~Owhyee~~	~~Canyon~~
~~Elmore~~	

~~(7-1-97)~~

~~**c.** *Southeast District.*~~

~~Southeast District~~	
~~Bear Lake~~	~~Bonneville~~
~~Caribou~~	~~Camas~~
~~Bannock~~	~~Lincoln~~
~~Franklin~~	~~Twin Falls~~
~~Oneida~~	~~Minidoka~~
~~Power~~	~~Bingham~~
~~Cassia~~	~~Gooding~~
~~Jerome~~	

~~(7-1-99)~~

~~**02. Nomination Ballot**. Upon the occurrence of a vacancy to be filled as provided by law, a nominating ballot is to be forwarded to each licensed optometrist residing in the state of Idaho pursuant to Section 54-1504, Idaho Code, and shall read as follows:~~ ~~(7-1-93)~~

~~**NOMINATING BALLOT FOR MEMBERS OF THE IDAHO STATE BOARD OF OPTOMETRY**~~

~~List below any number of names between one (1) and six (6) of persons you wish to nominate for appointment by the Governor to the Idaho State Board of Optometry. In order to be appointed by the Governor, a nominee must be a licensed optometrist in the state of Idaho and shall have been a resident of and lawfully practicing optometry within the State of Idaho for a period of at least five (5) years next preceding his appointment as required by Section 54-1505, Idaho Code. At least one (1) person appointed by the Governor must reside in each of the three (3) districts which are set as follows:~~

~~North District - Counties of Lemhi, Boundary, Bonner, Kootenai, Shoshone, Benewah, Latah, Clearwater, Nez Perce, Idaho, Valley, Adams, Lewis, Washington, Jefferson, Payette, Madison, Boise, Teton, Custer, Blaine, Butte, Clark and Fremont.~~

~~*Southwest District - Counties of Ada, Elmore, Gem, Canyon and Owyhee.*~~

~~*Southeast District - Counties of Bear Lake, Caribou, Bannock, Franklin, Oneida, Power, Cassia, Minidoka, Bonneville, Camas, Lincoln, Bingham, Gooding, Jerome, and Twin Falls.*~~

~~*MY NOMINATIONS ARE:*~~

~~***READ CAREFULLY***~~

~~*Instructions for return of the nominating ballot.*~~

~~*Do not sign or otherwise identify yourself on the foregoing ballot itself.*~~

~~*Do place the completed ballot in the envelope marked "Ballot," seal the ballot envelope, and sign and print your name on the outside of the envelope.*~~

~~*Do place the ballot envelope in an envelope addressed to Chief of the Occupational License Bureau, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702 on or before _____.*~~

~~*Ballot envelopes will first be verified to determine if the person returning the ballot is eligible to vote, the ballot envelope will be opened and the ballots themselves will be counted and the results tabulated and sent to the Governor as required by law. Ballot envelopes which cannot be verified will be set aside and the names listed therein not recorded.* (7-1-99)~~

~~1~~011. -- 124. (RESERVED)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.13.01 - RULES OF THE PHYSCIAL THERAPY LICENSURE BOARD

DOCKET NO. 24-1301-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2206, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011 Idaho Administrative Bulletin, Vol. 11-10, pages 523 through 526.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-2206, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 19, 2011.

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

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

The Physical Therapy Board is amending the continuing education rules to allow for additional credit and courses that may be pre-approved. This change will provide more pre-approved courses to licensees for fulfillment of continuing education requirements.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule changes were discussed in a noticed open meeting.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 19th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1301-1101

250. CONTINUING EDUCATION REQUIREMENT (RULE 250).
On and after January 1, 2008, every person holding a license issued by the Board must annually complete sixteen (16) contact hours of continuing education prior to license renewal. (3-19-07)

01. Contact Hours. The contact hours of continuing education shall be obtained in areas of study germane to the practice for which the license is issued as approved by the board. (3-19-07)

02. Documentation of Attendance. It shall be necessary for the applicant to provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be maintained by the licensee and provided to the board upon request by the board or its agent. (3-19-07)

03. Excess Hours. Continuing education hours accumulated during the twelve (12) months immediately preceding the license expiration date may be applied toward meeting the continuing education requirement for the next license renewal. Hours in excess of the required hours may be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. (3-19-07)

04. Compliance Audit. The board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the board of meeting the continuing education requirement be submitted to the bureau. Failure to provide proof of meeting the continuing education upon request of the board shall be grounds for disciplinary action. (3-19-07)

05. Special Exemption. The board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the board. (3-19-07)

06. Continuing Education Credit Hours. Hours of continuing education credit may be obtained by attending and participating in a continuing education activity approved by the Board. (3-19-07)

a. General Criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit: (3-19-07)

i. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee; (3-19-07)

ii. Pertains to subject matters integrally related and germane to the practice of the profession; (3-19-07)

iii. Conducted by individuals who have specialized education, training and experience to be considered qualified to present the subject matter of the program. The Board may request documentation of the qualifications of presenters; (3-19-07)

iv. Application for Board approval is accompanied by a paper, manual or outline which describes the specific offering and includes the program schedule, goals and objectives; and (3-19-07)

v. Provides proof of attendance to licensees in attendance including: Date, location, course title, presenter(s); Number of program contact hours (One (1) contact hour equals one (1) hour of continuing education credit.); and the official signature or verification of the program sponsor. (3-19-07)

b. Specific Criteria. Continuing education hours of credit may be obtained by: (3-19-07)

i. Presenting professional programs which meet the criteria listed in these rules. Two (2) hours of credit will be awarded for each hour of presentation by the licensee. A course schedule or brochure must be maintained for audit; (3-19-07)

ii. Providing official transcripts indicating successful completion of academic courses which apply to the field of physical therapy in order to receive the following continuing education credits: (3-19-07)

(1) One (1) academic semester hour = fifteen (15) continuing education hours of credit; (3-19-07)

(2) One (1) academic trimester hour = twelve (12) continuing education hours of credit; (3-19-07)

(3) One (1) academic quarter hour = ten (10) continuing education hours of credit. (3-19-07)

iii. Attending workshops, conferences, symposiums or electronically transmitted, live interactive conferences which relate directly to the professional competency of the licensee; (3-19-07)

iv. Authoring research or other activities which are published in a recognized professional publication. The licensee shall receive five (5) hours of credit per page; (3-19-07)

v. Viewing videotaped presentations if the following criteria are met: (3-19-07)

(1) There is a sponsoring group or agency; (3-19-07)

(2) There is a facilitator or program official present; (3-19-07)

(3) The program official may not be the only attendee; and (3-19-07)

(4) The program meets all the criteria specified in these rules; (3-19-07)

vi. Participating in home study courses that have a certificate of completion; (3-19-07)

vii. Participating in courses that have business-related topics: marketing, time management, government regulations, and other like topics; (3-19-07)

viii. Participating in courses that have personal skills topics: career burnout, communication skills, human relations, and other like topics; (4-7-11)

ix. Participating in courses that have general health topics: clinical research, CPR, child abuse reporting, and other like topics; ~~and~~ ~~(4-7-11)~~( )

x. Supervision of a physical therapist student or physical therapist assistant student in an accredited college program. The licensee shall receive four (4) hours of credit per year~~.~~; and ~~(4-7-11)~~( )

xi. Completion and awarding of Board Certification or recertification by American Board of Physical Therapy Specialists (ABPTS). The licensee shall receive sixteen (16) hours for the year the certification or recertification was received. ( )

07. Course Approval. Courses of study relevant to physical therapy and sponsored or provided by the following entities or organizations shall be approved for continuing education credits: ( )

a. The American Physical Therapy Association (APTA) or any of its sections or local chapters; or ( )

b. The Federation of State Boards of Physical Therapy (FSBPT); or ( )

c. Commission on Accreditation in Physical Therapy Education (CAPTE); or ( )

d. National Athletic Trainers Association (NATA); or ( )

e. A College or University which is accredited or a candidate for accreditation by the Northwest Association of Secondary and Higher Schools or any similar accrediting body; or ( )

f. Otherwise approved by the Board. ( )

0~~7~~8. Submitting False Reports or Failure to Comply. The Board may condition, limit, suspend, or refuse to renew the license of any individual whom the Board determines submitted a false report of continuing education or failed to comply with the continuing education requirements. (3-19-07)

0~~8~~9. Failure to Receive the Renewal Application. Failure to receive the renewal application shall not relieve the licensee of the responsibility of meeting the continuing education requirements and submitting the renewal application and renewal fee. (3-19-07)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.14.01 - RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3204, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011 Idaho Administrative Bulletin, Vol. 11-10, page 527.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3204, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 19, 2011.

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

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

The Board of Social Work Examiners is amending Rule 100 to clarify approved colleges and universities and to clarify an approved social work program. This change brings the training in line with national standards.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule changes were discussed in a noticed open meeting.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 19th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1401-1101

100. APPROVED COLLEGES AND UNIVERSITIES (RULE 100).
Any college, university, or school of social work that is accredited or is a candidate for accreditation by the Northwest ~~*Association of Secondary and Higher Schools*~~ Commission on Colleges and Universities or any similar accrediting body, and that offers a social work program that is accredited by the Council on Social Work Education (CSWE) or that is otherwise approved by the Board. The social work program must be a recognizable, coherent organizational entity within the institution. ~~*(4-7-11)*~~( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3404, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011 Idaho Administrative Bulletin, Vol. 11-10, pages 528 through 539.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 19, 2011.

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

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

The Board of Professional Counselors and Marriage and Family Therapists is amending several sections of its rules to update them to current standards, to provide clarification, and to simplify licensure by endorsement.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule changes were discussed in a noticed open meeting.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at 208 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 19th day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1501-1101

004. INCORPORATION BY REFERENCE (RULE 4).

01. ACA Code of Ethics. "ACA Code of Ethics ~~*and Standards of Practice*~~," as published by the American Counseling Association (ACA), effective 2005 and referenced in Subsections 200, 241.02, 350, and 450.01, is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(3-30-07)*~~( )

02. AAMFT Code of Ethics. The document titled "AAMFT Code of Ethics," as published by the American Association for Marriage and Family Therapy (AAMFT), effective July 1, 2001 and referenced in Subsections 350, and 450.01, is herein incorporated by reference and is available from the Board's office and on the Board web site. (3-30-06)

~~***03. ACES Guidelines**. The document titled "ACES" that provides supervision guidelines for supervisors, as published by the Association for Counselor Education and Supervision (ACES), dated March 1993 referenced in Subsection 200.03.a., is herein incorporated by reference and is available from the Board's office and on the Board web site.*~~
~~*(4-2-03)*~~

0~~4~~3. Guidelines. The document titled "Approved Supervision Designation Handbook" that provides supervision guidelines for supervisors, as published by the American Association for Marriage and Family Therapy (AAMFT), dated October 200~~2~~7 referenced in Subsection 240.03.a., is herein incorporated by reference and is available from the Board's office and on the Board web site. ~~*(3-20-04)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS (RULE 10).

01. Board. The Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists as prescribed in Section 54-3401, Idaho Code. (3-13-02)

02. Bureau. The Bureau of Occupational Licenses as prescribed in Sections 54-3404 and 67-2602, Idaho Code. (3-13-02)

03. Registered Intern. A~~n~~ registered intern shall be defined as a person who is obtaining required supervised experience for licensure in a course of study provided by an institution of higher education or a person who is in a private-practice setting acting under direct supervision. ~~*(3-13-02)*~~( )

04. Accredited University or College. An accredited university or college shall be a college or university accredited by one (1) of the following: ( )

a. The Middle States Association of Colleges and Schools; ( )

b. The New England Association of Schools and Colleges; ( )

c. The North Central Association of Colleges and Schools; ( )

d. The Northwest Association of Schools and of Colleges and Universities; ( )

e. The Southern Association of Colleges and Schools; or ( )

f. The Western Association of Schools and Colleges. ( )

011. -- 099. (RESERVED)

100. ORGANIZATION AND MEETINGS (RULE 100).
Board meetings will be held ~~*during the months of February, May, July, and October of*~~ not less than four (4) times each year and at such other times as the Board deems necessary.
~~*(3-13-02)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

150. QUALIFICATIONS FOR PROFESSIONAL COUNSELOR LICENSURE (RULE 150).
Licensure as a "professional counselor" shall be restricted to persons who have successfully completed the required examination and each of the following requirements: (3-30-06)

01. Graduate Program Requirement. A planned graduate program of sixty (60) semester hours which is primarily counseling in nature, six (6) semester hours of which are earned in an advanced counseling practicum, and including a graduate degree in a counseling field from an accredited university or college offering a graduate program in counseling. (7-1-93)

a. A planned graduate program in a counseling field shall be defined as completion of one (1) of the following: (7-1-93)

i. A counseling program approved by the Council for Accreditation of Counseling and Related Educational Programs; or (7-1-93)

ii. A counseling program approved by the Council on Rehabilitation Education; or (7-1-93)

iii. A counseling program approved by the Board which shows evidence of education

in the following areas: Counseling Theory, Counseling Techniques and Supervised Counseling Experience (this practicum must be supervised at the ratio of at least one (1) hour of one-to-one supervision for every ten (10) hours of experience in the setting). Applicant must show completion of one (1) graduate level course unique to each of the following eight (8) areas: (3-29-10)

(1) Human growth and development: Includes studies that provide a broad understanding of the nature and needs of individuals at all developmental levels. Emphasis is placed on psychological, sociological, and physiological approaches. Also included are areas such as human behavior (normal and abnormal), personality theory, and learning theory. (7-1-93)

(2) Social and cultural foundations: Includes studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns. (7-1-93)

(3) The helping relationship: Includes philosophic bases of the helping relationship: Consultation theory and/or an emphasis on the development of counselor and client (or consultee) self-awareness and self-understanding. (7-1-93)

(4) Groups: Includes theory and types of groups, as well as descriptions of group practices, methods dynamics, and facilitative skills. It includes either a supervised practice and/or a group experience. (7-1-93)

(5) Life-style and career development: Includes areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes, and career-development exploration techniques. (7-1-93)

(6) Appraisal of the individual: Includes the development of a framework for understanding the individual, including methods of data gathering and interpretation, individual and group testing, case-study approaches and the study of individual differences. Ethnic, cultural, and sex factors are also considered. (7-1-93)

(7) Research and evaluation: Includes areas such as statistics, research design, and development of research and demonstration proposals. It also includes understanding legislation relating to the development of research, program development, and demonstration proposals, as well as the development and evaluation of program objectives. (7-1-93)

(8) Professional orientation: Includes goals and objectives of professional counseling organizations, codes of ethics, legal consideration, standards of preparation, certification, and licensing and role of identity of counselors. (7-1-93)

b. A total of at least sixty (60) graduate semester hours or ninety (90) graduate quarter hours shall be required. (7-1-93)

c. Advanced counseling practicum shall be practica taken at the graduate school level. (7-1-93)

d. A graduate degree shall be one of the following beyond the baccalaureate level: The master's degree, the educational specialist certificate or degree, or the doctor's degree. (7-1-93)

~~**e.** *An accredited university or college shall be a college or university accredited by one (1) of the following: the Middle States Association of Colleges and Schools, the New England Association of Schools and Colleges, the North Central Association of Colleges and Schools, the Northwest Association of Schools and of Colleges and Universities, the Southern Association of Colleges and Schools, or the Western Association of Schools and Colleges.* (3-26-08)~~

02. Supervised Experience Requirement. One thousand (1,000) hours of supervised experience in counseling acceptable to the Board. (7-1-93)

a. One thousand (1,000) hours is defined as one thousand (1,000) clock hours of experience working in a counseling setting, four hundred (400) hours of which shall be direct client contact. Supervised experience in practica and/or internships taken at the graduate level may be utilized. The supervised experience shall include a minimum of one (1) hour of face-to-face or one-to-one (1/1) or one-to-two (1/2) ~~*consultation*~~ supervision with the supervisor for every twenty (20) hours of job/internship experience. Face-to-face may include a face-to-face setting provided by a secure live ~~*video*~~ electronic connection between the supervisor and supervisee. As stated under Subsection 150.01.a.i~~v~~ii. counseling practicum experience as opposed to job or internship experience shall be supervised at a ratio of one (1) hour of supervision for every ten (10) hours in the settings. For example: ~~(3-30-06)~~( )

i. A person in a twenty (20) hour per week job/internship who is receiving one (1) hour of individual supervision each week would accumulate one thousand (1,000) supervised hours in fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

ii. A person in a forty (40) hour per week setting with one (1) hour of supervision per week would still require fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

iii. A person in a forty (40) hour per week setting with two (2) hours of supervision per week would accumulate the one thousand (1,000) hours at the twenty to one (20/1) supervision ratio in twenty-five (25) weeks. (7-1-93)

b. Until July 1, 2004, the supervision must be provided by a Professional Counselor or a Clinical Professional Counselor licensed by the state of Idaho. Effective July 1, 2010, supervision must be provided by a counselor education faculty member at an accredited college or university, ~~*or a*~~ Professional Counselor, registered with the Board as a supervisor, a Clinical Professional Counselor, registered with the Board as a supervisor, ~~*or*~~ a Marriage and Family Therapist, registered with the Board as a supervisor, a Clinical Social Worker registered as a supervisor with the Board of Social Work, a licensed Psychologist, or a licensed Psychiatrist, licensed by the state of Idaho ~~*and registered with the Board as a Supervisor*~~. If the applicant's supervision was provided in another state, it must have been provided by a counseling professional licensed by that state, provided the requirements for licensure in that state are substantially equivalent to the requirements of Title 54, Chapter 34, Idaho Code. If supervision was obtained prior to July 1, 1988, or in a state that does not regulate counseling, that supervision must have been provided by a qualified counselor educator as a part of a planned graduate

program or by a person who holds a graduate degree beyond the baccalaureate level who is certified and/or licensed as a counselor, social worker, psychologist, or psychiatrist. Supervision by an administrative superior who is not in a counseling related profession is not acceptable to the Board. Supervision by a professional counseling peer, however, may be acceptable to the Board if the peer/supervisory relationship includes the same controls and procedures expected in an internship setting. (See Subsection 150.02.a.) For example, the relationship should include the staffing of cases, the critiquing of counseling tapes and this supervision must be conducted in a formal, professional, consistent manner on a regularly scheduled basis. ~~(3-29-10)~~( )

c. Experience in counseling is defined as assisting individuals or groups, through the counseling relationship, to develop an understanding of personal problems, to define goals, and to plan action reflecting interests, abilities, aptitudes, and needs as related to persona-social concerns, educational progress, and occupations and careers. Counseling experience may include the use of appraisal instruments, referral activities, and research findings. (7-1-93)

d. The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (4-2-03)

e. Supervision must be provided in compliance with the ACA code of ethics for counseling supervision, evaluation, remediation, and endorsement. ( )

151. -- 199. (RESERVED)

200. COUNSELOR SUPERVISOR REQUIREMENTS (RULE 200).
Effective July 1, 2004, Idaho licensed counselors shall be registered with the Board in order to provide ~~postgraduate~~ supervision for those individuals pursuing licensure in Idaho as a counselor. ~~(4-2-03)~~( )

01. Requirements for Registration. (4-2-03)

a. Document at least two (2) years experience as a licensed counselor. (3-30-07)

b. Document at least one thousand five hundred (1,500) hours of direct client contact as a counselor. (4-2-03)

c. Document fifteen (15) contact hours of education in supervisor training as approved by the Board. (4-2-03)

d. Have not been the subject of any disciplinary action for five (5) years prior to application for registration. (4-2-03)

02. Registration. A supervisor applicant shall submit to the Bureau a completed application form as approved by the Board. (4-2-03)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. The applicant shall include a copy of the informed consent form used to ensure clients are aware of the roles of the supervisor and supervisee, ~~(4-2-03)~~( )

b. A supervisor's registration shall be valid only so long as the individual's counselor license remains current and in good standing. (4-2-03)

03. Supervision. (4-2-03)

a. A Registered Counselor Supervisor shall provide supervision in conformance with the guidelines for supervisors ~~dated March 1993, adopted by the Association for Counselor Education and Supervision~~ set forth in the ACA Code of Ethics. ~~(4-2-03)~~( )

b. ~~A~~ Unless the primary work role of an individual is as a clinical supervisor a Registered Counselor Supervisor shall not provide supervision to more than six (6) ~~individuals~~ supervisees concurrently. ~~(3-30-06)~~( )

201. -- 224. (RESERVED)

225. CLINICAL PROFESSIONAL COUNSELOR LICENSURE (RULE 225).
Licensure as a "clinical professional counselor" shall be restricted to persons who have successfully ~~completed~~ passed the required examination and have met the following requirements: ~~(3-30-06)~~( )

~~**01. Requirements**. The following requirements must be met:~~ ~~(3-13-02)~~

~~a~~**01. License**. Hold a valid licensed professional counselor license; and ~~(4-2-03)~~( )

~~b~~**02. Experience**. Document two thousand (2,000) hours of direct client contact experience under supervision accumulated in no less than a two (2) year period after licensure in any state. ~~(4-2-03)~~( )

~~i~~**a.** All applicants for Clinical Professional Counselor license must provide verification of meeting at least one thousand (1,000) hours of supervised experience under the supervision of a licensed Clinical Professional Counselor registered as a supervisor with the Board. The remainder of the supervision may be provided by licensed Psychiatrists, ~~Counseling/ Clinical~~ Licensed Psychologists, Licensed Clinical Social Workers registered as supervisors with the Board of Social Work Examiners, or Marriage and Family Therapists registered as supervisors with the Board. ~~(3-30-07)~~( )

~~ii~~**b.** ~~The ratio for supervision will consist of~~ One (1) hour of clinical supervision for every thirty (30) hours of direct client contact is required. Individual supervision is defined as one (1) hour of face-to-face, one-on-one (1:1) or one-to-two (1:2) supervision to every thirty (30) hours of direct client contact. ~~(7-1-97)~~( )

~~iii~~**c.** No more than one-half (1/2) of group supervision shall be allowed. (3-30-07)

~~c~~**03. Examination**. Successful ~~completion~~ passage of the required written examination. ~~(3-30-06)~~( )

~~d~~**04. Recommendation of the Supervisor(s)**. The Board shall consider the

recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. ~~(4-2-03)~~( )

~~**02. Supervisors.** A supervisor may supervise no more than six (6) licensed professional counselors.~~ ~~(3-30-06)~~

(BREAK IN CONTINUITY OF SECTIONS)

238. MARRIAGE AND FAMILY THERAPISTS (RULE 238).
The following requirements must be met for marriage and family therapist licensure: (3-13-02)

01. Graduate Degree. Possess a graduate degree as outlined in Section 54-3405C(1), Idaho Code. (3-13-02)

02. Practicum. Must meet the requirements as outlined in Section 54-3405C(2), Idaho Code. (3-13-02)

03. Supervised Marriage and Family Therapy Experience. Must meet the three thousand (3,000) hour requirement as outlined in Section 54-3405C(3), Idaho Code. Effective July 1, 2004, a Idaho Marriage and Family Therapist must be registered with the Board to provide post graduate supervision for those pursuing marriage and family therapist licensure in Idaho. ~~(4-2-03)~~( )

a. A minimum of two thousand (2,000) postgraduate direct client contact hours, in no less than a two (2) year time period shall include; (3-13-02)

i. A minimum one thousand (1,000) direct client contact hours with couples and families; and (3-13-02)

ii. Two hundred (200) hours of supervision. (3-13-02)

b. ~~Supervision may~~ Effective July 1, 2014 a minimum of one hundred (100) hours post-graduate supervision must be obtained from a registered marriage and family therapist supervisor. The remaining one hundred (100) hours of ~~S~~supervision may also be obtained from a licensed clinical professional counselor registered as a supervisor with the Board, licensed psychologist, licensed clinical social worker registered as a supervisor with the Board of Social Work Examiners, or licensed psychiatrist who documents: ~~(3-26-08)~~( )

i. A minimum of five (5) years of experience providing marriage and family therapy; and (3-20-04)

ii. Fifteen (15) contact hours of education in supervisor training; and (3-20-04)

iii. Has not been the subject of any disciplinary action for five (5) years immediately prior to providing supervision. (3-20-04)

c. No more than one hundred (100) hours of group supervision shall be allowed. Group supervision shall be defined as ~~no more than~~ up to six (6) supervisees ~~per each~~ and one (1) supervisor; and ~~(3-13-02)~~( )

d. Individual supervision is defined as up to two (2) supervisees per supervisor; and (3-13-02)

e. Supervision must employ observation of client contact such as the use of audio technologies or video technologies or co-therapy, or live supervision; and ~~(3-13-02)~~( )

f. In accordance with the adopted Codes of Ethics prohibiting dual relationships, a supervisor shall not act as an applicant's personal Professional Counselor/Therapist. (3-13-02)

g. The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (4-2-03)

h. Supervision obtained in another state must conform with the state's requirements provided they are substantially equivalent to Idaho's requirements. ( )

04. Examination. (3-13-02)

a. The Board requires successful passage of the National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB). (3-13-02)

b. The examination will be conducted at a time and place specified by the Board. (3-13-02)

c. Successful passage of the examination is defined by the Board as achievement of the passing score set by the AMFTRB. Reexamination shall consist of the entire examination. (3-13-02)

239. MARRIAGE AND FAMILY THERAPIST SUPERVISOR REQUIREMENTS (RULE 239).
Effective July 1, 2004, licensed marriage and family therapists in Idaho shall be registered with the board to provide supervision for those individuals pursuing licensure in the state of Idaho as a marriage and family therapist. (3-20-04)

01. Requirements for Registration. (3-20-04)

a. Possess two (2) years experience as a licensed marriage and family therapist and document at least two thousand (2,000) hours of direct client contact with couples and families. (3-20-04)

b. Document fifteen (15) contact hours of education in supervisor training as approved by the Board. (3-20-04)

c. Have not been subject to discipline for five (5) years prior to registration. (3-20-04)

02. Registration. A marriage and family therapist shall fully complete the application form as established by the board and submit the designated fee as adopted by board rule. (3-20-04)

03. Supervision. (3-20-04)

a. A registered marriage and family therapist shall provide supervision in conformance with the guidelines for supervisors adopted by the American Association for Marriage and Family Therapists. (3-20-04)

b. Unless the primary work role of an individual is as a clinical supervisor ~~A~~a registered marriage and family therapist shall not supervise more than six (6) ~~individuals~~ supervisees, either in one-to-one or group supervision, at any time regardless of the modality (individual, dyad, or group) of supervision. ~~(3-20-04)~~( )

c. Face-to-face may include a face-to-face setting provided by a secure live electronic connection between the supervisor and supervisee. ( )

(BREAK IN CONTINUITY OF SECTIONS)

245. REGISTERED INTERNS (RULE 245).
An individual pursuing Idaho licensure as a Professional Counselor may register with the Board as an Intern. An individual pursuing Idaho licensure as a Marriage and Family Therapist shall be ~~licensed as~~ a~~n~~ Licensed Associate Marriage and Family Therapist or Licensed Professional Counselor, or register prior to commencement of supervised experience with the Board as an Intern in compliance with Section 54-3402, Idaho Code. If the Marriage and Family Therapist applicant's supervised experience was obtained out of state, such applicant must meet the requirements of Rule 238.03, except that applicant's supervisor need not be registered with the Board. ~~(3-29-10)~~( )

01. Requirements for Registration. (4-2-03)

a. Possess a graduate degree in counseling, marriage and family therapy, or a closely related field from an accredited university or college. (4-2-03)

b. Be actively pursuing postgraduate supervised experience. (4-2-03)

c. Designate a supervisor who is registered with the board as a supervisor as set forth in these rules or who is otherwise approved to provide marriage and family therapy supervision as defined in Section 54-3405C, Idaho Code, and who shall be responsible to provide supervision. ~~(3-20-04)~~( )

02. Registration. An individual applying for registration as a Counselor Intern or Marriage and Family Therapist Intern shall fully complete the application form as established by the Board and submit the designated fee as adopted by Board rule. (4-2-03)

03. Practice. (4-2-03)

a. A Registered Intern may only practice counseling or marriage and family therapy under the direct supervision of a Counselor Supervisor, registered with the Board or Marriage and Family Therapist Supervisor, registered with the Board who shall be responsible to ensure that a Registered Intern is competent to practice such counseling or marriage and family therapy as may be provided. ~~(4-2-03)~~( )

b. Only a Registered Intern may use the title Registered Counselor Intern or Registered Marriage and Family Therapist Intern. Registered interns must explicitly state that they are interns in their documentation and advertising, such as business cards, informed consent forms, and other disclosures. ~~(4-2-03)~~( )

c. An individual shall not practice as an intern for more than four (4) years from the original date of registration. (4-2-03)

(BREAK IN CONTINUITY OF SECTIONS)

300. ENDORSEMENT (RULE 300).
The Board may grant a license to any person who submits a completed application on a form approved by the Board together with the required fees and who: (3-13-02)

01. Holds a Current License. The applicant must be the holder of a current active license, in the profession and at the level for which a license is being sought, issued by the authorized regulatory entity in another state or foreign country. The state or foreign country must have substantially similar requirements for licensing as is provided for new applicants in Idaho. The certification of licensure must be received by the Board from the issuing agency; and ~~(3-29-10)~~( )

02. Has Not Been Disciplined. The applicant must have not been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily surrendered a license; and (3-29-10)

03. Is of Good Moral Character. The applicant must be of good moral character and have not been convicted, found guilty, or received a withheld judgment or suspended sentence for any felony; and (3-29-10)

04. Has Documented Experience. The applicant must provide a documented record of at least five (5) years actual practice under licensure in the seven (7) years immediately prior to application in the profession for which a license is being sought, or can demonstrate hardship or extenuating circumstances that prohibited practice during a portion of the ~~five~~ seven (~~5~~7) year

period as determined by the Board; and ~~(3-13-02)~~( )

05. Will Abide by Laws, Rules and Code of Ethics. The applicant must certify under oath to abide by the laws and rules governing the practice of counseling and marriage and family therapy in Idaho and the applicable code of ethics as adopted~~;~~. ~~and either~~ ~~(3-30-07)~~( )

~~***06. National Credential Registry**. If applicant has been granted credentials by the American Association of State Counseling Boards as qualifying for Category II of the national credential registry or any such similar qualification granted by a national credentialing entity otherwise approved by the Board; or*~~ ~~(3-30-07)~~

~~***07. Provides Information**. The applicant must document at least three (3) of the following during the five (5) years immediately prior to application:*~~ ~~(3-13-02)~~

~~***a.** A minimum of one thousand (1,000) hours client contact;*~~ ~~(3-13-02)~~

~~***b.** Service as an officer of a state or national counseling or marriage and family therapy organization, or a member of a state or national counseling or marriage and family therapy board or committee, or other leadership positions as may be approved by the Board;*~~ ~~(3-13-02)~~

~~***c.** Teaching at least three (3) graduate courses for credit at an accredited college or university;*~~ ~~(3-13-02)~~

~~***d.** A certificate to supervise issued by the NBCC or AAMFT;*~~ ~~(3-13-02)~~

~~***e.** Providing at least twelve (12) months of supervision to each of no less than three (3) persons seeking licensure;*~~ ~~(3-13-02)~~

~~***f.** Maintained professional liability insurance for the previous five (5) years with proof of no claims filed;*~~ ~~(3-13-02)~~

~~***g.** Obtained a post graduate degree in a field of study related to counseling or marriage and family therapy that is in addition to the minimum licensure requirements;* (3-13-02)~~

~~***h.** Current certification by a national credentialing entity as approved by the Board in the discipline for which licensure is sought;*~~ ~~(3-13-02)~~

~~***i.** A total of one hundred (100) hours of continuing education completed in the five (5) years immediately prior to application.*~~ ~~(3-26-08)~~

301. -- 349. (RESERVED)

350. CODE OF ETHICS (RULE 350).
The Board adopts the American Counseling Association (ACA) Code of Ethics and the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics as referenced in Section 004. ~~*All applicants will receive a copy of both the ACA Code of Ethics and the AAMFT Code of Ethics.*~~ All licensees shall be required to adhere to the appropriate Code of Ethics pertaining to

their licensure. ~~*(3-13-02)*~~( )

351. -- 359. (RESERVED)

360. INACTIVE STATUS (RULE 360).

01. Request for Inactive Status. Each person requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee. (3-26-08)

02. Inactive License Status. (3-26-08)

a. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho. (3-26-08)

b. Inactive license renewal notices and licenses will be marked "Inactive." (3-26-08)

c. When the licensee desires active status, the licensee must show acceptable fulfillment of continuing education requirements for the previous twelve (12) months and submit a fee equivalent to the difference between the inactive and active renewal fee. ~~*(3-26-08)*~~( )

d. Licensees shall not practice in Idaho as a Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or a Marriage and Family Therapist while on inactive status. ~~*(3-26-08)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

425. CONTINUING EDUCATION (RULE 425).
Every person holding an Idaho license as a Professional Counselor, Clinical Professional Counselor, Associate Marriage and Family Therapist, or a Marriage and Family Therapist must complete in each twelve-month period preceding the renewal of a license, twenty (20) contact hours of continuing education. A contact hour is one (1) hour of actual participation in a continuing education activity, exclusive of breaks. (3-29-10)

01. Contact Hours. The contact hours of continuing education must be obtained in areas of study germane to the practice for which the license is issued as approved by the Board. No less than three (3) contact hours for each renewal period must be in ethics, which must be specific to legal issues, law, or ethics. Ethics contact hours must be obtained in a face-to-face setting where you can interact with the instructor and students. Therapeutic workshops, retreats and other self-help activities are not considered continuing education training unless specific parts of the experience are applicable to counseling or therapy practice. ~~*(3-29-10)*~~( )

02. Documentation of Attendance. It shall be necessary for the licensee to maintain documentation verifying attendance by securing authorized signatures or other documentation

from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be provided to the Board upon request by the Board or its agent. (3-29-10)

03. Approved Contact Hours, Limitations, and Required Documents. (3-29-10)

a. College or University Courses for Credit or Audit. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. However, all courses are subject to Board approval. For college or university courses, one (1) semester credit equals fifteen (15) contact hours; one (1) quarter credit equals ten (10) contact hours. The licensee must provide the Board with a copy of the licensee's transcript substantiating any hours attended by the licensee. (3-29-10)

b. Seminars, Workshops, Conferences. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. Teleconferences must feature an interactive format in order to qualify for contact hour credit. Interactive conferences are those that provide the opportunity for participants to communicate directly with the instructor. The licensee must provide the Board with a copy of the certificate, or letter signed by course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. (3-29-10)

c. Publications. A maximum of four (4) contact hours may be counted in this category during each reporting period. Publication activities are limited to articles in journals, a chapter in an edited book, or a published book or professional publication. The licensee must provide the Board with a copy of the cover page or the article or book in which the licensee has been published. For a chapter in an edited book the licensee must submit a copy of the table of contents. (3-29-10)

d. Presentations. A maximum of four (4) contact hours may be counted in this category during each reporting period. Class, conference, or workshop ~~P~~presentations may be used for contact hour credit if the topic is germane to the field. A specific presentation given repeatedly can only be counted once. A particular presentation will qualify for contact hour credit one (1) time in a five (5) year period. Only actual presentation time may be counted; preparation time does not qualify for contact hour credit. The licensee must provide the Board with a copy of the conference program or a letter from the sponsor, host organization, or professional colleague. ~~(3-29-10)~~( )

e. Clinical Supervision and Case Consultation. A maximum of five (5) contact hours of received supervision/consultation may be counted in this category during each reporting period. In order to qualify for contact hour credit, supervision/consultation must be received on a regular basis with a set agenda. No credit will be given for the licensee's supervision of others. The licensee must provide the Board with a letter from the supervisor or consultant listing periods of supervision, where the supervision occurred, and the name of the supervisor. (3-29-10)

f. Dissertation. A maximum of five (5) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a copy of the licensee's transcript and the title of the dissertation. (3-29-10)

g. Leadership. A maximum of four (4) contact hours may be counted in this category during each reporting period. The licensee must provide the Board with a letter from a professional colleague listing the position of leadership, periods of leadership, and the name of the organization under which the leadership took place. The following leadership positions qualify for continuing education credits: (3-29-10)

i. Executive ~~O~~officer of a state or national counseling or therapy organization; ~~(3-29-10)~~( )

ii. Editor or editorial board service of a professional counseling or therapy journal; ~~(3-29-10)~~( )

iii. Member of a national ethics disciplinary review committee rendering licenses, certification, or professional membership; (3-29-10)

iv. Active member of a counseling or therapy working committee producing a substantial written product; (3-29-10)

v. Chair of a major counseling or therapy conference or convention; or (3-29-10)

vi. Other leadership positions with justifiable professional learning experiences. (3-29-10)

h. Home Study and On-line Education. A maximum of ten (10) contact hours may be counted through self-study during each reporting period. In order for a home study or on-line course to qualify for contact hours, the course must be provided by a Board-approved continuing education provider or a course pre-approved by the Board. ~~*Ethics contact hours cannot be earned through self-study or on-line education.*~~ ~~(3-29-10)~~( )

i. Copy of Certification Required. A licensee applying for home study or on-line credit must provide the Board a copy of the certification that is verified by the authorized signatures from the course instructors, providers, or sponsoring institution and substantiates any hours completed by the licensee. A licensee seeking contact credit for reading a publication must submit results from a test on the information contained within the publication and administered by an independent third-party. (3-29-10)

j. Continuing Education Credit. Continuing education credit may be granted for a maximum of two (2) hours each renewal period for time spent attending one (1) Board meeting. Members of the Board are not entitled to continuing education credit for Board service. (3-29-10)

04. Excess Hours. Continuing education hours accumulated during the twelve (12) months immediately preceding the license ~~*expiration*~~ renewal date may be applied toward meeting the continuing education requirement for the next license renewal. No more than ~~*five*~~ ten (~~5~~10) hours in excess of the required twenty (20) hours shall be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. ~~(4-2-03)~~( )

05. Compliance Audit. The Board may conduct random continuing education audits

of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the Board of meeting the continuing education requirement be submitted to the Bureau. Failure to provide proof of meeting the continuing education upon request of the Board shall be grounds for disciplinary action in accordance with section 54-3407, Idaho Code. (4-2-03)

06. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must request such exemption prior to renewal and provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board. There is no continuing education required of those holding a current inactive license. (3-29-10)

426. -- 449. (RESERVED)

450. GENERAL SCOPE OF THE LICENSEE'S APPROPRIATE PRACTICE (RULE 450).

~~01.~~ **Board Recommendation of Generic Scope of Practice**. While a license to practice as a counselor or therapist could be considered generic in nature, it should not be viewed as an authorization to provide counseling or therapy services to every client population in every possible professional setting. Counselors and marriage and family therapists shall practice only within the boundaries of competence (see the applicable Code of Ethics). ~~(3-13-02)~~( )

~~02. Submission of Additional Information for Scope of Practice. A licensed counselor or marriage and family therapist who considers the Board's recommended guidelines to be too restrictive may wish to submit additional information to acquaint the Board with new, possibly more expansive qualifications.~~ ~~(3-13-02)~~

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.19.01 - RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

DOCKET NO. 24-1901-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-4205, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011 Idaho Administrative Bulletin, Vol. 11-8, pages 217 and 218.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-4205, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

The 2011 legislature passed House Bill 49 which revised the education and experience qualifications necessary for licensure as a Residential Care Facility Administrator. The bill also provided the Board discretion to accept other combinations of education and experience. This rule change implements the qualifications for licensure consistent with the statute. Rule 150 specifies the age, education and experience requirement, and the coursework and examination requirement.

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

The 2011 legislature passed House Bill 49 which revised the education and experience qualifications necessary for licensure as a Residential Care Facility Administrator. The bill also provided the Board discretion to accept other combinations of education and experience. This rule change is necessary to implement the changes in statute.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule proposal was discussed in a noticed open meeting

and implements changes to the Statute.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 7th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1901-1101

150. QUALIFICATIONS FOR ADMINISTRATOR LICENSE (RULE 150).
Each applicant for an administrator's license ~~*and each licensed administrator, as requested by the Board,*~~ shall submit proof, along with their application, that said individual is at least twenty-one (21) years of age and meets all the following qualifications for the issuance of a license~~*or permit, or the retention or renewal of a license*~~: ~~*(4-6-05)*~~( )

01. Good Moral Character. The applicant shall cause to be submitted a criminal background check by an entity approved by the Board establishing that the applicant has not been convicted, pled guilty or nolo contendere or received a withheld judgment for a felony or any crime involving dishonesty or the health or safety of a person. (3-30-06)

02. Education and Experience. The applicant shall document one (1) of the combinations of education and experience in accordance with Section 54-4206, Idaho Code, and Subsection 400 of these rules. ( )

03. Coursework. The applicant shall document completion of a specialized course or program of study as set forth in Subsection 400 of these rules. ( )

04. Examination. The applicant shall submit proof of successful passage of a relevant examination as approved by the Board and defined in Subsection 300 of these rules. ( )

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.23.01 - RULES OF THE SPEECH AND HEARING SERVICES LICENSURE BOARD

DOCKET NO. 24-2301-1101

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-2910, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the August 3, 2011 Idaho Administrative Bulletin, Vol. 11-8, pages 221 and 222.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at 208 334-3233.

DATED this 4th day of November, 2011.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W State
Boise, ID 83702
Phone: (208) 334-3233
Fax: (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is **July 1, 2011**.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-2910, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 17, 2011.

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

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

The 2011 legislature passed House Bill 47 which amended Section 54-2918, Idaho Code, to provide for licensure by endorsement and educational equivalency. This new rule implements the statute and Rule 310 provides the qualifications for licensure by endorsement.

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

The 2011 legislature passed House Bill 47 which amended Section 54-2918, Idaho Code, to provide for licensure by endorsement and educational equivalency. This new rule implements the statute and provides the qualifications for licensure by endorsement.

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

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

There is no impact to dedicated or general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule proposal was discussed in a noticed open meeting and implements changes to the Statute.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cherie Simpson at (208) 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 24, 2011.

DATED this 7th day of July, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-2301-1101

301. -- 3~~4~~09. (RESERVED)

310. ENDORSEMENT (RULE 310).
The Board may grant a license to any person who submits a completed application on a form approved by the Board, together with the required fees, and who meets the following prerequisites: ( )

01. Holds a Current, Active License. The applicant must hold a current, active license, at the level for which a license is being sought, issued by the authorized regulatory entity in another state, the certification of which must be received directly by the Board from the issuing agency. ( )

02. Discipline, Sanctions, or Voluntary Surrender of License. The applicant must not have been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily surrendered a license. ( )

03. No Felony Conviction. The applicant must not have been convicted of or found guilty of a felony, or received a withheld judgment or suspended sentence for any felony. ( )

04. Must Abide by Governing Laws and Rules. The applicant must certify under oath to abide by the laws and rules governing the practice of Speech and Hearing Services in Idaho. ( )

310. -- 349. (RESERVED)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1101 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2012 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the October 5, 2011 Idaho Administrative Bulletin, Vol. 11-10, page 558.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mark Johnston, R.Ph., Executive Director. (208) 334-2356.

DATED this 29th day of November, 2011.

Mark Johnston, R.Ph., Executive Director
Idaho State Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208)334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

Wednesday, October 26th, at 1:00 p.m. MST

Hilton Garden Inn - Les Bois Room
7699 West Spectrum Street, Boise, ID

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

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

It is necessary to repeal the Board's existing rules and to promulgate new and reorganized rules to provide Board licensees and registrants, subject to regulation under the Idaho Pharmacy Act and the Uniform Controlled Substances Act, the Out-of-State Mail Service Pharmacy Act, and the Wholesale Drug Distribution Act, an updated and more comprehensive set of rules governing the practice of pharmacy in Idaho. This action repeals this chapter in its entirely. The rewritten rule is being published in the Bulletin immediately following this notice under Docket No. 27-0101-1102.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notices of Intent to Promulgate Rules - Negotiated Rulemaking were published in the May 4, 2011, Vol. 11-5, page 74; June 1, 2011, Vol. 11-6, page 38; and August 3, 2011, Vol. 11-8, page 225, Idaho Administrative Bulletins.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed repeal of this rule, contact Mark Johnston, R.Ph., Executive Director, (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written

comments must be directed to the undersigned and must be delivered on or before October 26, 2011.

DATED this 31st day of August, 2011.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1101

IDAPA 27.01.01 IS BEING REPEALED IN ITS ENTIRETY