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**IDAPA 16
TITLE 03
Chapter 09**

16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE

000. LEGAL AUTHORITY.

Pursuant to Section 56-202(b), Idaho Code, the Idaho Legislature has delegated to the Department of Health and Welfare the responsibility to establish and enforce such rules and such methods of administration as may be necessary or proper to administer public assistance programs within the state of Idaho. Pursuant to Section 56-203(g), Idaho Code, the Idaho Legislature has empowered the Department to define persons entitled to medical assistance in such terms as will meet the requirements for federal financial participation in medical assistance payments. (11-10-81)

001. TITLE AND SCOPE.

01. Title. These rules are to be cited as Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, "Rules Governing the Medical Assistance Program." (11-10-81)

02. Scope. Pursuant to Section 56-203(i), Idaho Code, these rules set forth general provisions regarding the administration of the Title XIX Medical Assistance Program within the state of Idaho and identifies the amount, duration, and scope of care and services to be purchased as medical assistance on behalf of needy eligible individuals. All goods and services not specifically included in this chapter are excluded from coverage under Medical Assistance. (9-1-82)

002. POLICY.

It is the policy of the Department, as provided in accordance with Section 56-209(b), Idaho Code, that medical assistance will be made available to all recipients of old-age assistance, aid to dependent children, aid to the blind, aid to the permanently and totally disabled, and other persons covered by Title XIX of the Social Security Act. (11-10-81)

003. DEFINITIONS.

For the purposes of these rules, the following terms will be used, as defined below: (11-10-81)

01. 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. This Subsection is effective retroactively from October 1, 1993. (2-17-94)

02. Access Unit (ACCESS). Access to Care Coordination, Evaluation, Services and Supports. A regional multidisciplinary, transdivisional unit that has the responsibility of determining eligibility, authorizing services, and assuring quality for services and supports for individuals with developmental disabilities. (7-1-95)

03. 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. (7-1-97)

04. Bill. The itemized cost of all services provided to one (1) recipient on a single claim form. (11-10-81)

05. Bureau. The Bureau of Medicaid Policy and Reimbursement within the Division of Medicaid, Idaho Department of Health and Welfare, which has the responsibility for administration of the Medical Assistance Program for the state of Idaho. (7-1-97)

06. Bureau of Systems and Operations. A Bureau of the Division of Medicaid charged with the responsibility of investigation and seeking prosecution of cases involving Medicaid fraud. (7-1-97)

07. Buy-In Coverage. The amount the State pays for Part B of Title C XVIII on behalf of the A/R.3 (11-10-81)

08. Category I Sanctions. Less severe administrative sanctions, which can be employed concurrently, which neither require notification nor are subject to appeal unless specifically allowed. (11-10-81)
09. Category II Sanctions. Severe administrative sanctions which are appealable as provided for in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-97)
10. Central Office. The administrative headquarters for the Idaho Department of Health and Welfare which are located in the State Office Building (State Towers), 450 West State Street, Boise, Idaho 83720. (11-10-81)
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. (7-1-97)
12. Claim. An itemized bill for services rendered to one (1) recipient by a provider submitted on any of the following Department claim forms: (11-10-81)
- a. DHW PH 3-80, "Physician Invoice" or such other claim form as may be prescribed by the Department; or (11-10-81)
 - b. DHW 03-80, "Title XIX Pharmacy Claim;" or (11-10-81)
 - c. DHW-AD78, "Adjustment Request;" or (11-10-81)
 - d. DHW OP REV 4-80, "Hospital Out-patient;" or (11-10-81)
 - e. DHW IP 3-80, "Hospital In-patient;" or (11-10-81)
 - f. DHW 0137, "Attending Dentist's Statement;" or (11-10-81)
 - g. DHW NH 3-80, "Nursing Home Statement;" or (11-10-81)
 - h. HW-0034 "Consent Form" for sterilization procedures. (11-10-81)
13. Collateral Contacts. Contacts made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record. (10-6-88)
14. Community Living Home. A licensed ICF/MR facility of eight (8) beds or less that has converted to a group home to provide residential habilitation services to developmentally disabled waiver recipients. Room and board is not included in the reimbursement rate. (7-1-95)
15. Contraception. The provision of drugs or devices to prevent pregnancy. (1-16-80)
16. Department. The state of Idaho Department of Health and Welfare (DHW). (11-10-81)
17. Director. The Director of the Idaho Department of Health and Welfare. (11-10-81)
18. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which can withstand repeated use by one or more individual, 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 MA recipient. (11-1-86)
19. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the recipient or required by federal and state educational statutes or

regulations; are not "related services" as listed in Section 120; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (12-31-91)

20. Eligibility Manuals. IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled." (7-1-97)

21. Emergency. Any situation arising in the medical condition of a patient, which, after applying the prevailing medical standards of judgement and practice within the community requires immediate medical intervention. All obstetrical deliveries are considered emergencies. (10-29-92)

22. Endangerment of Life. A condition where, in the opinion of two (2) licensed physicians, a pregnant woman may die or suffer severe and long lasting physical health damage if the fetus is carried to term. (1-16-80)

23. Health Authority. An authorized official of any of the seven (7) Idaho District Health Departments or their satellite centers. (1-16-80)

24. 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, Subsection 002.11, "Rules for Proprietary Home Health Agencies." (7-1-97)

25. 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. (11-10-81)

26. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (2-5-93)

27. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance recipients. Such a team is composed of: (7-1-94)

- a. At least one (1) registered nurse; and (7-1-94)
- b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (7-1-94)
 - i. A consultant physician; or (7-1-94)
 - ii. A consultant social worker; or (7-1-94)
 - iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (7-1-94)

28. Interested Physician. (11-10-81)

- a. A physician who performs a Medicaid funded abortion for a fee; or (11-10-81)
- b. A physician who is related by blood or marriage to another physician performing a Medicaid funded abortion. (11-10-81)

29. 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 Sanatoria. (11-10-81)

30. Law Enforcement Authority. An agency recognized by the state of Idaho in enforcement of established state and federal statutes. (11-10-81)

31. 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. (11-10-81)

32. Licensed Psychologist. An individual who is licensed to practice psychology under Chapter 23, Title 54, Idaho Code. (10-6-88)

33. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (11-10-81)

34. Lock-in Program. An administrative sanction, required of recipients found to have misused the services provided by the Medical Assistance Program, requiring the recipient to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (11-10-81)

35. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (11-10-81)

36. Medical Necessity. A service is medically necessary if: (7-1-97)

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

b. There is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (T)

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

37. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (11-1-86)

38. Morbid Obesity. The condition of a person who exceeds ideal weight by more than one hundred (100) pounds and who has significant medical complications directly related to weight gain. (7-1-97)

39. Non-legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (11-10-81)

40. Nurse Midwife. A registered nurse (RN) who is currently licensed to practice in Idaho, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one of the following provisions: (11-10-81)

a. Is currently certified as a Nurse Midwife by the American College of Nurse Midwives; or (11-10-81)

b. Has satisfactorily completed a formal educational program of at least one (1) academic year that: (11-10-81)

i. Prepares a RN to furnish gynecological and obstetrical care to women during pregnancy, delivery and postpartum, and care to normal newborns; (11-10-81)

ii. Upon completion, qualifies a RN to take the certification examination offered by the American College of Nurse Midwives; (11-10-81)

iii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of

- supervised clinical practice; and (11-10-81)
- iv. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)
41. Nurse Practitioner. A registered nurse (RN) who is currently licensed to practice in this State, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one (1) of the following provisions: (11-10-81)
- a. Is currently certified as a Primary Care Nurse Practitioner by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates, or by the Nurses Association of the American College of Obstetricians and Gynecologists; or (11-10-81)
- b. Has satisfactorily completed a formal one (1) year academic year educational program that: (11-10-81)
- i. Prepares a RN to perform an expanded role in the delivery of primary care; (11-10-81)
- ii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)
- iii. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)
42. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for residents. The residents must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision; which are made available to them only through institutional facilities, not primarily for care and treatment of mental diseases. The institution is licensed in the state of Idaho pursuant to Section 39-1301, Idaho Code and is certified as a nursing facility pursuant to 42 CFR 405.1120 through 405.1136. (7-1-94)
43. Orthotic. Pertaining to or promoting the straightening of a deformed or distorted part. (10-1-91)
44. Orthotic and Prosthetic Professional. An individual certified or registered by the American Board for Certification in Orthotics and/or Prosthetics. (10-1-91)
45. Otologist. A licensed physician who specializes in the diagnosis and treatment of hearing disorders and diseases of the ear. (11-10-81)
46. Out-patient 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 hospital bed accommodation. (11-10-81)
47. 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. (7-1-97)
48. 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. (11-1-86)
49. Patient. The person undergoing treatment or receiving services from a provider. (11-10-81)
50. 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. (10-1-91)

51. Physician's Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-97)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (11-10-81)

b. Has satisfactorily completed a program for preparing physician's assistants that: (11-10-81)

i. Was at least one (1) academic year in length; and (11-10-81)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (11-10-81)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (11-10-81)

52. Plan of Care. A written description of medical, remedial and/or rehabilitative services to be provided to a recipient, 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. (10-6-88)

53. Premium or Subscription Charge. The per capita amount paid by the Department for each eligible MA recipient enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a recipient receives care and services during the contract period. (11-10-81)

54. Property. The homestead and all personal and real property in which the recipient has a legal interest. (11-10-81)

55. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (10-1-91)

a. Artificially replace a missing portion of the body; or (10-1-91)

b. Prevent or correct physical deformities or malfunctions; or (10-1-91)

c. Support a weak or deformed portion of the body. (10-1-91)

56. Provider. Any individual, organization or business entity furnishing medical goods or services in compliance with this chapter and who has applied for and received a provider number, pursuant to Section 020, and who has entered into a written provider agreement, pursuant to Section 040. (7-1-97)

57. Provider Agreement. An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)

58. Provider Reimbursement Manual. IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho." (7-1-97)

59. Psychology Assistant. An individual who practices psychology under the supervision of a licensed psychologist when required under Chapter 23, Title 54, Idaho Code, and Section H of the "Rules of the Idaho State Board of Psychologist Examiners." (7-1-94)

60. Recipient. An individual who is receiving Medical Assistance. (11-10-81)

61. 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, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (10-6-88)

62. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX long term care for the Department. (7-1-94)

63. 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. (11-10-81)

64. Specialized Family Home. Living situation where a maximum of two (2) waiver recipients who do not require a skilled nursing service live with a provider family of residential habilitation services. (7-1-95)

65. Subluxation. A partial or incomplete dislocation of the spine. (11-10-81)

66. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (6-21-90)

67. Title XVIII. That program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled. The term is interchangeable with "Medicare." (11-10-81)

68. Title XIX. That program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as "Medicaid," which is jointly financed by the federal and state governments and administered by the states. The term is interchangeable with "Medicaid." (11-10-81)

69. 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 recipient of medical assistance. (11-10-81)

70. Transportation. The physical movement of a recipient to and from a medical appointment or service by the recipient, another person, taxi or common carrier. (10-6-88)

71. 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/recipients to Title XIX benefits in a NF. (7-1-94)

72. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the NFs approved by the Department as providers of care for eligible medical assistance recipients. (7-1-94)

73. 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 recipient would be able to participate in a sheltered workshop or in the general work force within one (1) year. (10-6-88)

004. ABBREVIATIONS.

For these rules, the following abbreviations will be as defined: (7-1-93)

01. AABD. Aid to the Aged, Blind, and Disabled. (11-10-81)

02. AAP. American Academy of Pediatrics. (8-1-92)

03. APA. The Administrative Procedures Act, Title 67, Chapter 52, Idaho Code. (11-10-81)

04. A/R. Applicant/Recipient. (11-10-81)

05. ASC. Ambulatory Surgical Center. (9-30-84)

06. ASHA. American Speech and Hearing Association. (11-10-81)

07.	B.I.A. Bureau of Indian Affairs.	(11-10-81)
08.	CFR. Code of Federal Regulations.	(11-10-81)
09.	CRNA. Certified Registered Nurse Anesthetist.	(7-1-97)
10.	CRVS. California Relative Value Studies.	(11-10-81)
11.	DME. Durable Medical Equipment.	(11-1-86)
12.	D.O. Doctor of Osteopathy.	(11-10-81)
13.	DVR. Department of Vocational Rehabilitation.	(11-10-81)
14.	EAC. Estimated Acquisition Cost.	(11-10-81)
15.	EOMB. Explanation of Medical Benefits.	(11-10-81)
16.	EPSDT. Early and Periodic Screening, Diagnosis, and Treatment.	(11-10-81)
17.	ICF/MD. Intermediate Care Facility/Medical Disease.	(11-10-81)
18.	ICF/MR. Intermediate Care Facility/Mentally Retarded.	(11-10-81)
19.	IOC. Inspection of Care.	(1-1-83)
20.	IOCT. Inspection of Care Team.	(1-1-83)
21.	IRS. Internal Revenue Service.	(11-10-81)
22.	MA. Medical Assistance.	(11-10-81)
23.	MAC. Maximum Allowable Cost.	(11-10-81)
24.	M.D. Medical Doctor.	(11-10-81)
25.	MMIS. Medicaid Management Information System.	(11-10-81)
26.	NF. Licensed Nursing Facility.	(8-1-92)
27.	PASARR. Preadmission Screening and Annual Resident Review.	(7-1-94)
28.	PSRO. Professional Services Review Organization.	(11-10-81)
29.	QMHP. Qualified Mental Health Professional.	(7-1-94)
30.	QMRP. Qualified Mental Retardation Professional.	(4-30-92)
31.	REOMB. Recipient's Explanation of Medicaid Benefits.	(11-10-81)
32.	R.N. Registered Nurse.	(4-30-92)
33.	RSDI. Retirement, Survivors, and Disability Insurance.	(11-10-81)
34.	SMA. State Maximum Allowance.	(11-10-81)

- 35. SSA. Social Security Administration. (11-10-81)
- 36. SSI. Supplemental Security Income. (11-10-81)
- 37. S/UR. Surveillance and Utilization Review. (11-10-81)
- 38. TPL. Third Party Liability. (11-10-81)
- 39. UC. Utilization Control. (7-1-94)
- 40. UCT. Utilization Control Team. (7-1-94)
- 41. UR. Utilization Review. (11-10-81)

005. SINGLE STATE AGENCY AND STATEWIDE OPERATION.

The Idaho Department of Health and Welfare has the authority to administer the Title XIX Medical Assistance Program on a statewide basis in accordance with standards mandatory throughout the State and set forth herein. (11-10-81)

006. -- 009. (RESERVED).

010. PUBLIC ACCESS TO PROGRAM INFORMATION.

01. Location of Rules Governing Medical Assistance. A current copy of the rules governing medical assistance, as well as other MA program information affecting the public, is to be maintained by the Department in the Central Office and in each field office. (11-10-81)

02. Availability of Materials. Copies of the rules governing medical assistance or other MA program information affecting the public will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 01, "Rules Governing the Protection and Disclosure of Department Records (Confidentiality)": (11-10-81)

- a. Formally requests specific information; or (11-10-81)
- b. Formally requests to be placed on a mailing list to receive amendments to MA program policy from the Department's Administrative Procedure Section. (11-10-81)

03. Cost of Materials. A fee, to cover actual reproduction costs, will be assessed for all requests for copies of information. (11-10-81)

011. -- 013. (RESERVED).

014. COORDINATED CARE.

01. Establishment. The Department may, in its discretion, and in consultation with local communities, organize and develop area specific plans as part of a coordinated care program. (6-1-94)

a. Flexibility. Since community needs and resources differ from area to area, the Department will maintain the flexibility to design plans which are consistent with local needs and resources. (6-1-94)

b. Waiver Programs. Plans may be either voluntary, or mandatory pursuant to waiver(s) granted by the Health Care Financing Administration. Some plans may start as voluntary and subsequently become mandatory. (6-1-94)

c. Models. It is anticipated that coordinated care will be accomplished principally through primary care case management. However, capitated plans may also be utilized. (6-1-94)

- d. Purpose. The purposes of coordinated care are to: (6-1-94)
 - i. Ensure needed access to health care; (6-1-94)
 - ii. Provide health education; (6-1-94)
 - iii. Promote continuity of care; (6-1-94)
 - iv. Strengthen the patient/physician relationship; and, (6-1-94)
 - v. Achieve cost efficiencies. (6-1-94)
- 02. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (6-1-94)
 - a. "Clinic" means two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs) and Certified Rural Health Clinics. (6-1-94)
 - b. "Coordinated care" is the provision of health care services through a single point of entry for the purposes of managing patient care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as "managed care." (6-1-94)
 - c. "Covered services" means those medical services and supplies for which reimbursement is available under the state plan. (6-1-94)
 - d. "Emergency care" means the immediate services required for the treatment of a condition for which a delay in treatment could result in death or permanent impairment of health. (6-1-94)
 - e. "Grievance" means the formal process by which problems and complaints related to coordinated care are addressed and resolved. Grievance decisions may be appealed as provided herein. (6-1-94)
 - f. "Non-exempt services" means those covered services which require a referral from the primary care provider. It includes all services except those that are specifically exempted. (6-1-94)
 - g. "Outside services" means non-exempt covered services provided by other than the primary care provider. (6-1-94)
 - h. "Patient/recipient" means any patient who is eligible for medical assistance and for which a provider seeks reimbursement from the Department. (6-1-94)
 - i. "Plan" means the area specific provisions, requirements and procedures related to the coordinated care program. (6-1-94)
 - j. "Primary care case management" means the process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient. (6-1-94)
 - k. "Qualified medical professional" means a duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (6-1-94)
 - l. "Referral" means the process by which patient/recipients gain access to non-exempt covered services not provided by the primary care provider. It is the authorization for non-exempt outside services. (6-1-94)

m. "Waiver" means the authorization obtained from the Health Care Financing Administration to impose various mandatory requirements related to coordinated care as provided in Sections 1915(b) and 1115 of the Social Security Act. (6-1-94)

03. Primary Care Case Management. Under this model of coordinated care, each patient/recipient obtains medical services through a single primary care provider. This provider either provides the needed service, or arranges for non-exempt services by referral. This management function neither reduces nor expands the scope of covered services. (6-1-94)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the patient/recipient's care, providing primary care services, and making referrals for outside services when medically necessary. All outside services not specifically exempted require a referral. Outside services provided without a referral will not be paid. All referrals shall be documented in recipient's patient record. (6-1-94)

b. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: family planning services, emergency care, dental care, Podiatry, Audiology, Optical/Ophthalmology/Optomist services, chiropractic, pharmacy, nursing home, ICF/MR services, and immunizations. (6-1-94)

04. Participation. (6-1-94)

a. Provider Participation. (6-1-94)

i. Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (6-1-94)

ii. Conditions and Restrictions. (6-1-94)

(1) Quality of Services. Provider shall maintain and provide services in accordance with community standards of care. Provider shall exercise his/her best efforts to effectively control utilization of services. Providers must provide twenty-four (24) hour coverage by telephone to assure patient/recipient access to services. (6-1-94)

(2) Provider Agreements. Providers participating in primary care case management must sign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals. (6-1-94)

(3) Patient Limits. Providers may limit the number of patient/recipients they wish to manage. Subject to this limit, the provider must accept all patient/recipients who either elect or are assigned to provider, unless disenrolled in accordance with the next Subsection. Providers may change their limit effective the first day of any month by written request thirty (30) days prior to the effective date of change. (6-1-94)

(4) Disenrollment. Instances may arise where the provider/patient relationship breaks down due to failure of the patient to follow the plan of care or for other reasons. Accordingly, a provider may choose to withdraw as patient/recipient's primary care provider effective the first day of any month by written notice to the patient/recipient and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (6-1-94)

(5) Record Retention. Providers must retain patient and financial records and provide the Department or its agent access to those records for a minimum of five (5) years from the date of service. Upon the reassignment of a patient/recipient to another provider, the provider must transfer (if a request is made) a copy of the patient's medical record to the new provider. Provider must also disclose information required by Subsection 040.01 of this chapter, when applicable. (6-1-94)

(6) Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 040.03 of this chapter. An agreement may be amended for the same reasons. (6-1-94)

iii. Payment. Providers will be paid a case management fee for primary care case management services

in an amount determined by the Department. The fee will be based on the number of patient/recipients enrolled under the provider on the first day of each month. For providers reimbursed based on costs, such as Federally Qualified Health Centers and Rural Health Clinics, the case management fee is considered one hundred percent (100%) of the reasonable costs of an ambulatory service. (6-1-94)

b. Recipient Participation. (6-1-94)

i. Enrollment. (6-1-94)

(1) Voluntary Programs. In voluntary plans, the patient/recipient will be given an opportunity to choose a primary care provider. If the patient/recipient is unable to choose a provider but wishes to participate in the plan, a provider will be assigned by the Department. If a voluntary plan subsequently becomes mandatory, provider selection/assignment will remain unchanged where possible. (6-1-94)

(2) Mandatory Programs. In mandatory plans, a provider will be assigned if the patient/recipient fails to choose a participating provider after given the opportunity to do so. Members of the same family do not have to choose the same provider. All patient/recipients in the plan area are required to participate in the plan unless individually granted an exception. Exceptions from participation in mandatory plans are available for patient/recipients who: (6-1-94)

(a) Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary care services; (6-1-94)

(b) Have an eligibility period that is less than three (3) months; (6-1-94)

(c) Live in an area excluded from the waiver; (6-1-94)

(d) Have an eligibility period that is only retroactive; or (6-1-94)

(e) Are eligible only as medically needy. (6-1-94)

ii. Changing Providers. If a patient/recipient is dissatisfied with his/her provider, he/she may change providers effective the first day of any month by requesting to do so in writing no later than fifteen (15) days in advance. This advance notice requirement may be waived by the Department. (6-1-94)

iii. Changing Service Areas. Patient/recipients enrolled in a plan cannot obtain non-exempt services without a referral from their primary care provider. Patient/recipients who move from the area where they are enrolled must disenroll in the same manner as provided in the preceding paragraph for changing providers, and may obtain a referral from their primary care provider pending the transfer. Such referrals are valid not to exceed thirty (30) days. (6-1-94)

05. Problem Resolution. (6-1-94)

a. Intent. To help assure the success of coordinated care, the Department intends to provide a mechanism for timely and personal attention to problems and complaints related to the program. (6-1-94)

b. Local Program Representative. To facilitate problem resolution, each area will have a designated representative at the local or regional level who will receive and attempt to resolve all complaints and problems related to the plan and function as a liaison between patient/recipients and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (6-1-94)

c. Registering a Complaint. Both patient/recipients and providers may register a complaint or notify the Department of a problem related to the coordinated care plan either by writing or telephoning the local program representative. All problems and complaints received will be logged. The health representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (6-1-94)

d. Grievance. If a patient/recipient or provider is not satisfied with the resolution of a problem or complaint addressed by the program representative, he may file a formal grievance in writing to the representative. The representative may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (6-1-94)

e. Appeal. Decisions in response to grievances may be appealed. Appeals by patient/recipients are considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings, IDAPA 16, Title 05, Chapter 03, and must be filed in accordance with the provisions of that chapter. (6-1-94)

015. CHOICE OF PROVIDERS.

01. Service Selection. Each recipient may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the MA Program, or from setting standards relating to the qualifications of providers of such care. (6-1-94)

02. Lock-In Option. (7-1-93)

a. The Department may implement a total or partial lock-in program for any recipient found to be misusing the MA Program according to provisions in Subsection 190.05; but (12-31-91)

b. In situations where the recipient has been restricted to a recipient lock-in program, that recipient may choose the physician and pharmacy of his choice. The providers chosen by the lock-in recipient will be identified on the recipient's identification card each month. (11-10-81)

03. Out-of-State Care Provided Outside the State of Idaho. All out-of-state medical care requires preauthorization by the Department or the Department's designated Peer Review Organization (PRO), with the exception of bordering counties and emergency or urgent medical care. (2-15-93)

a. MA recipients may receive medical care and services from providers located in counties bordering Idaho without preauthorization by the Department. However PRO review may be required pursuant to Subsections 070.04 and 080.02. Approval by the Bureau of Medicaid Policy and Reimbursement, or its successor, is required for all long-term care outside the state of Idaho pursuant to Subsection 015.03.e. (2-15-93)

b. Emergency/urgent out-of-state care. (2-15-93)

i. Emergency/urgent inpatient hospital care must be reviewed using the same procedures and guidelines as in-state emergency hospital admissions by the PRO. Transfers from an Idaho hospital to an out-of-state nonadjacent county hospital must be reviewed using the same procedures and guidelines as in-state transfers by the PRO. (7-1-97)

ii. Emergency/urgent out-of-state outpatient hospital, clinic and/or physician services do not require review by the Department or the Department's approved PRO. The provider must supply sufficient information to support a finding that the care provided was for an emergency/urgent situation. (2-15-93)

c. The Department or its designee will preauthorize all nonemergency care provided out-of-state for outpatient hospital services, rural health clinics, federally qualified health centers, physician services and physician extender services, dental services, podiatrists services, optometric services, chiropractor services, home health services, physical therapy services, occupational therapy services, speech and audiology services, private duty nursing, clinic services, rehabilitative services, and personal care services. (7-1-97)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-

of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipient's residence or if no preauthorization was obtained prior to the date of the service as required. (7-1-97)

iii. The only exceptions to the preauthorization requirement are: (2-15-93)

(1) When eligibility for Medicaid is determined after the service was provided. The service still must be determined to be not available closer to the recipient's residence. (2-15-93)

(2) Out-of-state nonadjacent county lab and x-ray services when the recipient does not have to travel outside the state for the services to be provided. (2-15-93)

(3) Mail order pharmacies will not require preauthorization when the recipient is not required to travel outside the state to receive the service. (2-15-93)

(4) Services for which Medicare is the primary payer of service. (2-15-93)

d. The Department's designated Peer Review Organization (PRO) will preauthorize all nonemergency inpatient hospital care provided out-of-state in a nonadjacent county. (2-15-93)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipient's residence or if no preauthorization was obtained prior to the date of the service as required. (7-1-97)

iii. The treating physician and the admitting facility is responsible for assuring that the Department's designated PRO has preauthorized the out-of-state nonemergency service for inpatient care. (2-15-93)

iv. No payment for services not preauthorized by the Department's designated PRO may be obtained from the recipient, absent the Medicaid recipient's informed decision to incur the cost of services. (2-15-93)

v. The only exceptions to the preauthorization requirement are: (2-15-93)

(1) When eligibility for Medicaid is determined after the service was provided. The service still must be determined not to be available closer to the recipient's residence. (2-15-93)

(2) Services for which Medicare is the primary payer of service. (2-15-93)

vi. The PRO review will be governed by provisions of the PRO provider manual as amended. (2-15-93)

e. Long-term care outside the State may be approved by the Department on an individual basis in temporary or emergency situations. Nursing home care will be limited to the period of time required to safely transport the recipient to an Idaho facility. Out-of-state care will not be approved on a permanent basis. (11-10-81)

016. -- 019. (RESERVED).

020. PROVIDER APPLICATION PROCESS.

01. In-state Provider Application. In-state providers may apply for provider numbers with the Bureau. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Bureau will confirm the status for all applicants with the appropriate licensing board and assign a Medicaid provider number(s). (3-22-93)

02. Out-of-State Provider Application. Out-of-state providers who wish to participate in the Medical Assistance Program must complete a provider application and be assigned a provider number by the Bureau. The Bureau will contact a representative of Medicaid or a licensing agency in the state in which the provider practices to confirm the provider applicant's professional status and license number. (11-10-81)

03. Denial of Provider Application. The Bureau must not accept the application of a provider who is suspended from Medicare or Medicaid in another state. (11-10-81)

021. PATIENT "ADVANCED DIRECTIVES".

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: (4-30-92)

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advanced directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. (4-30-92)

i. The provider must explain that the recipient has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the recipient has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (4-30-92)

ii. The provider will inform the recipient of their rights to formulate advance directives, such as "Living Will" and/or "Durable Power of Attorney For Health Care." (4-30-92)

iii. The provider must comply with Subsection 021.02. (4-30-92)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the recipient's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the recipient's right to accept or refuse medical and surgical treatment. (4-30-92)

c. Document in the recipient's medical record whether the recipient has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care") or, have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care"). (4-30-92)

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that recipient has executed an "Advance Directive." (4-30-92)

e. If the provider cannot comply with the patient's "Living Will" and/or "Durable Power of Attorney for Health Care" as a matter of conscience, the provider will assist the recipient in transferring to a facility/provider that can comply. (4-30-92)

f. Provide education to their staff and the community on issues concerning advanced directives. (4-30-92)

02. When "Advanced Directives" Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advanced Directives" to adult recipients in the following situations: (4-30-92)

a. Hospitals must give the information at the time of the recipient's admission as an inpatient unless Subsection 021.03 applies. (4-30-92)

- b. Nursing facilities must give the information at the time of the recipient's admission as a resident. (4-30-92)
 - c. Home health providers must give the information to the recipient in advance of the recipient coming under the care of the provider. (4-30-92)
 - d. The personal care R.N. supervisors will inform the recipient when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the QMRP and the personal care attendant of the recipient's decision regarding "Advanced Directives". (4-30-92)
 - e. A hospice provider must give information at the time of initial receipt of hospice care by the recipient. (4-30-92)
03. Information Concerning "Advanced Directives" at the Time an Incapacitated Individual is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once he is no longer incapacitated. (4-30-92)
04. Provider Agreement. The provider will sign a "Memorandum of Understanding Regarding Advance Directives" with the Department until the "Patient's Notification of Advanced Directives" is incorporated within the Provider Agreement. By signing the Memorandum of Understanding or the Medicaid Provider Agreement, the provider is not excused from its obligation regarding advanced directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. (4-30-92)

022. -- 024. (RESERVED).

025. LIENS AND ESTATE RECOVERY.

Pursuant to Sections 56-218 and 56-218A, Idaho Code, this subsection sets forth the provisions for recovery of MA, the filing of liens against the property of deceased persons, and the filing of liens against the property of permanently institutionalized recipients. ()

- 01. MA Incorrectly Paid. The Department may, pursuant to a judgment of a court, file a lien against the property of a living or deceased person of any age to recover the costs of MA incorrectly paid. ()
- 02. Administrative Appeals. Permanent institutionalization determination and undue hardship waiver hearings shall be governed by the fair hearing provisions of IDAPA 16, Title 05, Chapter 03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ()
- 03. Definitions. The following terms are applicable to Section 025 of these rules: ()
 - a. Authorized representative. The person appointed by the court as the personal representative in a probate proceeding or, if none, the person identified by the recipient to receive notice and make decisions on estate matters. ()
 - b. Equity interest in a home. Any equity interest in real property recognized under Idaho law. ()
 - c. Estate. All real and personal property and other assets including those in which the recipient had any legal or beneficial title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assignee of the deceased recipient through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. ()
 - d. Home. The dwelling in which the recipient has an ownership interest, and which the recipient occupied as his primary dwelling prior to, or subsequent to, his admission to a medical institution. ()

e. Institutionalized recipient. An inpatient in a nursing facility (NF), intermediate care facility for the mentally retarded (ICF/MR), or other medical institution, who is a Medicaid recipient subject to post-eligibility treatment of income in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." ()

f. Lawfully residing. Residing in a manner not contrary to or forbidden by law, and with the recipient's knowledge and consent. ()

g. Permanently institutionalized. An institutionalized recipient of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. ()

h. Personal property. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. ()

i. Real property. Any land, including buildings or immovable objects attached permanently to the land. ()

j. Residing in the home on a continuous basis. Occupying the home as the primary dwelling and continuing to occupy such dwelling as the primary residence. ()

k. Termination of a lien. The release or dissolution of a lien from property. ()

l. Undue hardship. Conditions that justify waiver of all or a part of the Department's claim against an estate, described in Subsections 025.25 through 025.29 of these rules. ()

m. Undue hardship waiver. A decision made by the Department to relinquish or limit its claim to any or all estate assets of a deceased recipient based on good cause. ()

04. Notification to Department. All notification regarding liens and estate claims shall be directed to the Department of Health and Welfare, Estate Recovery Unit, Towers Building, Sixth Floor, P.O. Box 83720, 450 W. State St. Boise, Idaho, 83720-0036. ()

05. Lien Imposed During Lifetime of Recipient. During the lifetime of the permanently institutionalized recipient, and subject to the restrictions set forth in Subsection 025.08 of these rules, the Department may impose a lien against the real property of the recipient for MA correctly paid on his behalf. The lien shall be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the recipient is permanently institutionalized. The lien shall be effective from the beginning of the most recent continuous period of the recipient's institutionalization, but not before July 1, 1995. Any lien imposed shall dissolve upon the recipient's discharge from the medical institution and return home. ()

06. Determination of Permanent Institutionalization. The Department must determine that the recipient is permanently institutionalized prior to the lien being imposed. An expectation or plan that the recipient will return home with the support of Home and Community Based Services shall not, in and of itself, justify a decision that he is reasonably expected to be discharged to return home. The following factors shall be considered when making the determination of permanent institutionalization: ()

a. The recipient must meet the criteria for NF or ICF/MR level of care and services as set forth in Subsections 180.03 and 180.08 of these rules; and ()

b. The medical records, including information set forth in Subsections 180.02 and 180.07 of these rules, shall be reviewed to determine if the recipient's condition is expected to improve to the extent that he will not require NF or ICF/MR level of care; and ()

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information, or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. ()

07. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the recipient or his authorized representative, in writing, of its intention to make a determination that the recipient is permanently institutionalized, and that he has the right to a fair hearing in accordance with Subsection 025.02 of these rules. This notice shall include the following information: ()

a. The notice shall inform the recipient that the Department's decision that he cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude him from returning home with services necessary to support NF or ICF/MR level of care; and ()

b. The notice shall inform the recipient that he or his authorized representative may request a fair hearing prior to the Department's final determination that he is permanently institutionalized. The notice shall include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice shall include the time limits and instructions for requesting a fair hearing. ()

c. The notice shall inform the recipient that if he or his authorized representative does not request a fair hearing within the time limits specified, his real property, including his home, may be subject to a lien, contingent upon the restrictions in Subsection 025.08 of these rules. ()

08. Restrictions on Imposing Lien During Lifetime of Recipient. A lien may be imposed on the recipient's real property; however, no lien may be imposed on the recipient's home if any of the following is lawfully residing in such home: ()

a. The spouse of the recipient; ()

b. The recipient's child who is under age twenty-one (21), or who is blind or disabled as defined in 42 U.S.C. 1382c as amended; or ()

c. A sibling of the recipient who has an equity interest in the recipient's home and who was residing in such home for a period of at least one (1) year immediately before the date of the recipient's admission to the medical institution, and who has been residing in the home on a continuous basis. ()

09. Restrictions on Recovery on Lien Imposed During Lifetime of Recipient. Recovery shall be made on the lien from the recipient's estate, or at any time upon the sale of the property subject to the lien, but only after the death of the recipient's surviving spouse, if any, and only at a time when: ()

a. The recipient has no surviving child who is under age twenty-one (21); ()

b. The recipient has no surviving child of any age who is blind or disabled as defined in 42 U.S.C. 1382c as amended; and ()

c. In the case of a lien on a recipient's home, when none of the following is lawfully residing in such home who has lawfully resided in the home on a continuous basis since the date of the recipient's admission to the medical institution: ()

i. A sibling of the recipient, who was residing in the recipient's home for a period of at least one (1) year immediately before the date of the recipient's admission to the medical institution; or ()

ii. A son or daughter of the recipient, who was residing in the recipient's home for a period of at least two (2) years immediately before the date of the recipient's admission to the medical institution, and who establishes by a preponderance of the evidence that he provided necessary care to the recipient, and the care he provided allowed the recipient to remain at home rather than in a medical institution. ()

10. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Recipient. Should the property upon which a lien is imposed be sold prior to the recipient's death, the Department shall seek recovery of all MA paid on behalf of the recipient, subject to the restrictions in Subsection 025.09 of these rules. Recovery of the

MA paid on behalf of the recipient from the proceeds from the sale of the property does not preclude the Department from recovering additional MA paid from the recipient's estate as described in Subsection 025.14 of these rules. ()

11. Filing of Lien During Lifetime of Recipient. When appropriate, the Department shall file, in the office of the Recorder of the county in which the real property of the recipient is located, a verified statement, in writing, setting forth the following: ()

- a. The name and last known address of the recipient; and ()
- b. The name and address of the official or agent of the Department filing the lien; and ()
- c. A brief description of the MA received by the recipient; and ()
- d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as MA benefits are paid on behalf of the recipient. ()

12. Renewal of Lien Imposed During Lifetime of Recipient. The lien, or any extension thereof, shall be renewed every five (5) years by filing a new verified statement as required in Subsection 025.11 of these rules, or as required by Idaho law. ()

13. Termination of Lien Imposed During Lifetime of Recipient. The lien shall be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien shall dissolve in the event of the recipient's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt and the estate remains subject to recovery under estate recovery provisions in Subsections 025.14 through 025.30 of these rules. A request for release of the lien shall be directed to the Department of Health and Welfare, Estate Recovery Unit, Towers Building, Sixth Floor, P.O. Box 83720, 450 W. State St., Boise, Idaho, 83720-0036. ()

14. Estate Recovery. Pursuant to Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: ()

- a. The costs of all MA correctly paid on or after July 1, 1995, on behalf of a recipient who was permanently institutionalized; and ()
- b. The costs of MA correctly paid on behalf of a recipient who received MA at age fifty-five (55) or older on or after July 1, 1994; and ()
- c. The costs of MA correctly paid on behalf of a recipient who received MA at age sixty-five (65) or older on or after July 1, 1988. ()

15. Recovery from Estate of Spouse. If the deceased recipient has no estate, recovery shall be made from the estate of his surviving spouse. ()

16. Lien Imposed Against Estate of Deceased Recipient. The Department may impose a lien against all property of the estate of an applicable recipient to secure its claim against the estate. To perfect a lien the Department shall, within ninety (90) days after the Department is notified, in writing, of the death of the MA recipient, file a lien in the same general form and manner as provided in Subsection 025.11 of these rules. Failure to file a lien does not affect the validity of claims made against the estate. A request for release of the lien shall be directed to the Department of Health and Welfare, Estate Recovery Unit, Towers Building, Sixth Floor, P.O. Box 83720, 450 W. State St., Boise, Idaho, 83720-0036. ()

17. Notice of Estate Claim. The Department shall notify the authorized representative of the amount of the estate claim after the death of the recipient, or after the death of the surviving spouse. The notice shall include instructions for applying for an undue hardship waiver. ()

18. Assets in Estate Subject to Claims. The authorized representative shall be notified of the

Department's claim against the assets of a deceased recipient. Assets in the estate from which the claim can be satisfied shall include all real or personal property that the deceased recipient owned or in which he had an ownership interest, including the following: ()

a. Payments to the recipient under an installment contract shall be included among the assets of the deceased recipient. This includes an installment contract on any real or personal property to which the deceased recipient had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the recipient. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. ()

b. The deceased recipient's ownership interest in an estate, probated or not probated, is an asset of his estate when: ()

i. Documents show the deceased recipient is an eligible devisee or donee of property of another deceased person; or ()

ii. The deceased recipient received income from property of another person; or ()

iii. State intestacy laws award the deceased recipient a share in the distribution of the property of another estate. ()

c. Any trust instrument which is designed to hold or to distribute funds or property, real or personal, in which the deceased recipient has a beneficial interest is an asset of the estate. ()

d. Life insurance is considered an asset when it has reverted to the estate. ()

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. The funds remaining after payment to the funeral home shall be considered assets of the estate, provided no contingent beneficiary is designated. ()

f. Checking and savings accounts which hold and accumulate funds designated for the deceased recipient, are assets of the estate, including joint accounts which accumulate funds for the benefit of the recipient. ()

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a recipient prior to his death, absent evidence to the contrary, such funds are an asset of the deceased recipient's estate, even if a court has to approve release of the funds. ()

h. Shares of stocks, bonds and mutual funds to the benefit of the deceased recipient are assets of the estate. The current market value of all stocks, bonds and mutual funds must be proved as of the month preceding settlement of the estate claim. ()

19. Value of Estate Assets. The Department shall use fair market value as the value of the estate assets. ()

20. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased recipient shall be subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a surviving spouse of a predeceased recipient is limited to the value of the assets of the estate that were community property, or the deceased recipient's share of the separate property, and jointly owned property. Recovery shall not be made until the deceased recipient no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and, when applicable, as provided in Subsection 025.09 of these rules. No recovery shall be made if the recipient received MA as the result of a crime committed against the recipient. ()

21. Expenses Deducted from Estate. The following expenses shall be deducted from the available assets to determine the amount available to satisfy the Department's claim: ()

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

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

22. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. ()

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

24. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement which separates assets for a married couple does not eliminate the debt against the estate of the deceased recipient or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. ()

25. Release of Estate Claims. The Department shall release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: ()

a. When an undue hardship waiver as defined in Subsection 025.26 of these rules has been granted; or ()

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

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

27. Application for Undue Hardship Waiver. An applicant for an undue hardship waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the recipient or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding shall constitute notice to all heirs. ()

28. Basis for Undue Hardship Waiver. Undue hardship waivers shall be considered in the following circumstances: ()

a. The estate subject to recovery is the sole income-producing asset of the survivors where such income is limited; or ()

b. Payment of the Department's claim would cause heirs of the deceased recipient to be eligible for public assistance; or ()

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

d. The recipient received MA as the result of a crime committed against the recipient. ()

29. Limitations on Undue Hardship Waiver. Any beneficiary of the estate of a deceased recipient may

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

30. Set Aside of Transfers. Transfers of real or personal property of the recipient without adequate consideration are voidable and may be set aside by the district court. ()

026. CONDITIONS FOR PAYMENT.

01. Recipient Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the MA recipient in the month of payment, provided that each of the following conditions are met: (11-10-81)

a. The recipient was found eligible for MA for the month, day, and year during which the medical care and services were rendered; and (11-10-81)

b. The recipient received such medical care and services no earlier than the third month before the month in which application was made on such recipient's behalf; and (11-10-81)

c. Not more than twelve (12) months have elapsed since the month of the latest recipient services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (11-10-81)

02. Time Limits. The time limit set forth in Subsection 026.01.c. shall not apply with respect to retroactive adjustment payments. (12-31-91)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid recipients. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. (3-22-93)

027. -- 029. (RESERVED).

030. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for the medical care and services included under the MA Program, the need for which arises out of injury, disease, or disability of an MA recipient. (11-10-81)

02. Third Party Liability as a Current Resource. In determining whether MA is payable, 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. (11-10-81)

03. Withholding Payment. The Department must not withhold payment on behalf of an eligible MA recipient 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 recipient's medical expense. (11-10-81)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party for MA when the party's liability is established after MA is granted, 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 absent parent without a second valid resource, prenatal, EPSDT, and EPSDT related services. (2-4-91)

a. The Department will seek reimbursement for MA from a recipient when a recipient's liability is established after MA has been granted; and (11-10-81)

b. In any other situation in which the recipient has received direct payment from any third party resource and has not returned the money to the Department for MA service received. (11-10-81)

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. (2-4-91)

06. Accident Determination. When the patient'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. (11-10-81)

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 MA for the services. (11-10-81)

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a recipient and that recipient is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the recipient 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. (11-10-81)

a. If litigation or a settlement in such a claim is pursued by the MA recipient, the recipient must notify the Department. (11-10-81)

b. If the recipient recovers funds, either by settlement or judgment, from such a third party, the recipient must repay the amount of benefits paid by the Department on his behalf. (11-10-81)

09. Subrogation of Legal Fees. (11-10-81)

a. If an MA recipient 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 recipient 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 recipient. (11-10-81)

b. If a settlement or judgment is received by the recipient 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 recipient in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the recipient. (11-10-81)

031. MEDICAID COST RECOVERY FROM PARENTS.

The Department intends to recover from a child's parent, all or part of the cost of Medicaid services to the child in a Nursing Facility (NF), in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), in a Personal Care Services (PCS) provider's home under twenty-four (24) hour care, or under Home Care for Certain Disabled Children (HCCDC). The child must be under eighteen (18). Recovery is from the child's natural or adoptive parent. Recovery is made under Sections 32-1003, 56-203B, and 56-209b, Idaho Code. Upon application for Medicaid, the applicant assigns to the state of Idaho his rights to recover payments for his medical expenses from any liable third party, including a parent. Recovery will not be made for a child receiving adoption assistance under Title IVE of the Social Security Act, or under the State Adoption Assistance Program. The Examiner must tell the parent(s) of a child applying for Medicaid help with NF, ICF/MR, twenty-four (24) hour care in a PCS provider's home, or HCCDC, that he may be required to share in the cost of Medicaid services for the child. No eligible child will be denied Medicaid services if a responsible parent fails to pay the assessment. Medicaid payments to providers will not be reduced if the parent fails to pay. (7-1-97)

01. Parent Gross Assessment Income. Parent gross assessment income is the parents' adjusted gross income as reported on the last calendar year's state income tax form 40 (Total Adjusted Income) or 40EZ (Adjusted Gross Income). Parents who did not reside in Idaho for the entire year must use the federal income tax form 1040 or 1040A (Adjusted Gross Income). (7-1-97)

a. Parents living together and filing separately must use their combined income from both individuals' tax returns. Where the child's parent lives with the child's stepparent, the amount on the line entitled "Total Adjusted Income" or "Adjusted Gross Income" on either tax form must be adjusted by subtracting the stepparent's income. (7-1-97)

b. Parents who have not yet filed a tax return must provide an estimated adjusted gross income amount. The tax return must be provided to the Department when filed. (7-1-97)

c. Parents who claim this year's income is substantially different from their previous adjusted gross federal or state income must provide proof of their actual income. (7-1-97)

d. Parents whose adjusted gross income includes a substantial proportion of non-liquid earnings may petition for an adjustment to their gross assessment income. Such adjustment may be granted following a contested case hearing, at which the burden shall be upon the parent to show by clear and convincing evidence that it would be manifestly unfair to assess the full amount of the adjusted gross income. Any present adjustment to the gross assessment income shall include the recapture of any deferred amount at a time when the non-liquid portion of the parent's earnings are or become subject to liquidation. The amount to be recaptured may be required to be secured by an appropriate instrument. (7-1-97)

02. Stepparent Income. Where the parent's spouse is the child's stepparent, the parent's community property interest in the stepparent's income is not income to the parent for calculating the parent's assessment income (AI). (7-6-94)

03. Two (2) Parent Assessment. Where the child's parents are living apart, each parent is separately assessed. The assessment of each parent is lowered, if necessary, so the total assessment for the child is not more than the Medicaid payments made for the child during the assessment year. (7-6-94)

04. Family Size. Family size includes the child's natural, step, or adoptive parents if living in the home. Family size also includes natural and adoptive siblings if living in the same home. Family size does not include the child's step siblings. The Medicaid child under HCCDC is included if living in the home and is counted twice in the calculation of the family size. (7-1-97)

05. Annual Assessment Calculation. The annual assessment is based on the AI and family size. Calculate the annual assessment following the steps in Subsections 031.05.a. through 031.05.d. The Third Party Recovery (TPR) unit calculates the assessment based on information provided by the parent. (7-1-97)

a. Step 1. From the parent's AI, deduct all payments for court-ordered child support. (7-6-94)

b. Step 2. From the AI, subtract two hundred percent (200%) of the Federal Poverty Guideline (FPG) for the family size. The FPG is published annually in the Federal Register by the federal Office of Management and Budget. The annual FPG change takes effect the following July for calculating the assessment. (7-6-94)

c. Step 3. Multiply the result from Step 2, up to fifty thousand dollars (\$50,000), by ten percent (10%), between fifty thousand dollars (\$50,000) and sixty thousand dollars (\$60,000) by twelve percent (12%), between sixty thousand dollars (\$60,000) and seventy-five thousand dollars (\$75,000) by fourteen percent (14%), and multiply the remainder over seventy-five thousand dollars (\$75,000) by fifteen percent (15%). (7-6-94)

d. Step 4. Add together the results of each calculation in Step 3. Add the total to the amount calculated in Step 2. This is the annual assessment. (7-6-94)

e. Step 5. From the amount in Step 4, deduct the annual amount paid for health insurance premiums if

this insurance covers the Medicaid child. (7-6-94)

06. Monthly Assessment Amount. The monthly assessment is determined by dividing the annual assessment calculated in Subsection 031.05 by twelve (12). Where the child is living in a nursing facility or ICF/MR and is not receiving Supplemental Security Income (SSI) or other income, his thirty dollar (\$30) personal needs allowance is deducted from the monthly assessment. (7-6-94)

07. Initial Assessment. The parent(s) will be identified by the Field Office when a child applies for or receives Medicaid help in the cost of NF or ICF/MR care or applies for HCCDC Medicaid or twenty-four (24) hour care in a PCS provider's home. The Field Office will provide this information to the TPR unit. (7-1-97)

08. TPR Contact. The TPR unit will notify the parent(s), in writing, of their legal responsibility to share in the cost of NF, ICF/MR, HCCDC, or other Medicaid services for the child. The notice will be sent within thirty (30) days of the date the child's Medicaid application is approved. Income and expense reporting forms will be provided to the parent(s). The parent can provide his IRS income tax forms for the previous year in place of an income report. (7-1-97)

09. Noncooperation. A monthly assessment equal to the average Medicaid reimbursement rate for the child's level of care, as published by the Department for the previous year, is used if a parent fails to provide income information; provides false or misleading statements; misrepresents, conceals or withholds facts to avoid financial responsibility. (7-6-94)

10. Notice of Assessment Amount and Hearing Rights. The TPR unit sends the parent(s) written notice of the assessment amount within ten (10) days of the date the assessment is calculated, and notice of the parent's right to a hearing in accordance with Subsection 031.20 of these rules. The notice shall include the following information: (7-1-97)

- a. The notice shall inform the parent of the amount calculated as the monthly assessment. (7-1-97)
- b. The notice shall inform the parent that he or she may request a hearing to contest the Department's calculation of the assessment amount. The notice shall include information that a pre-hearing conference may be scheduled prior to a hearing. The notice shall include the time limits and instructions for requesting a hearing. (7-1-97)
- c. The notice shall inform the parent that if he or she does not request a hearing within the time limits TPR Unit will be used. (7-1-97)
- d. The notice shall inform the parent that only a parent who owes an assessment amount may request a hearing. (7-1-97)

11. Assessment Year. The first assessment year is the twelve (12) month period beginning with the effective month of the child's eligibility for Medicaid. Subsequent assessment years are twelve (12) month periods beginning the same calendar month as the first assessment year began. (7-1-97)

12. Assessment Limit. The total assessment for an assessment year will not exceed the Medicaid payments made for the child for the assessment year. (7-6-94)

13. Interim Adjustments. The assessment amount can be adjusted up to four (4) times during an assessment year, if the parent asks for recalculation, based on lower AI. The parent must prove his AI is lower than income used for the yearly assessment. Recalculation is not automatic when the assessment formula changes in January. (7-6-94)

14. Annual Adjustment. The AI is recalculated yearly in the same month as the initial assessment. The assessment is adjusted, if necessary. The parent must be sent a notice of the adjusted assessment. The parent can request an adjustment of the yearly assessment. The parent must provide a copy of his federal or state tax filing for that calendar year or other proof of annual income. The annual income is compared to the parent's AI for that tax year. If the AI is less than the AI used to calculate the assessment, the assessment is adjusted. (7-1-97)

15. Annual Reconciliation. The parent's assessment and the Medicaid cost excluding services provided by school districts or developmental disability centers for the child are reconciled at assessment year end. If the parent paid more than the Medicaid cost for the child, a credit is issued. If the child is no longer a Medicaid recipient, a refund is issued. Where a parent has more than one (1) child whose Medicaid costs are subject to recovery, the monthly assessment will be divided by the number of children whose costs are subject to recovery. Each child's prorated share of the assessment is then compared to the Medicaid costs for that child to determine whether a refund will be issued. No reconciliation is required where the difference between the projected AI and actual income for the tax year is a minimum of three thousand dollars (\$3,000) or ten percent (10%) of annual AI, whichever is more.

(7-6-94)

16. Annual Support Deduction Reconciliation. Where the parent paid more child support than was deducted, he is entitled to a credit or refund, if he so chooses. If the child is no longer a recipient of NF, ICF/MR, twenty-four (24) hour care in a PCS provider's home or HCCDC Medicaid, the parent is entitled to a refund of the amount he overpaid.

(7-1-97)

17. Payment Schedule. The parent may pay his annual assessment in four (4) payments yearly, for services already paid or projected to be paid by Medicaid. The parent may negotiate a different payment schedule with the TPR Unit.

(7-6-94)

18. Enforcement. Failure of a responsible parent to pay the assessment will be referred to the Office of the Attorney General for initiation of collection proceedings and appropriate legal action, including civil suit, garnishment, attachment, and any other legal process to accomplish the purpose of Sections 32-1003, 56-203B and 56-209b, Idaho Code. Collection will be enforced by the Bureau of Child Support Services (BCSS).

(7-1-97)

19. Out-of-State Parents. Responsible parents living out-of-state will be contacted and assessed to the same extent as Idaho residents. The Department may enter into reciprocity of enforcement agreements with states with similar provisions.

(7-6-94)

20. Administrative Appeals. Hearings to contest the Department's calculation of the assessment amount shall be governed by the hearing provisions of IDAPA 16, Title 05, Chapter 03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."

(7-1-97)

032. -- 035. (RESERVED).

036. REPORTING TO IRS.

Pursuant to 26 USC 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number.

(11-10-81)

037. -- 039. (RESERVED).

040. AGREEMENTS WITH PROVIDERS.

01. In General. The Department will enter into written agreements with each provider or group of providers of supplies or services under the Program. Agreements may contain any terms or conditions deemed appropriate by the Department. Each agreement will contain, among others, the following terms and conditions requiring the provider:

(3-2-94)

a. To retain for a minimum of three (3) years any records necessary for a determination of the services the provider furnishes to recipients; and

(11-10-81)

b. To furnish to the Bureau, the Secretary of the U.S. Department of Health and Human Services, the Fraud Investigation Bureau, or the Department of Law Enforcement any information requested regarding payments claimed by the provider for services; and

(11-10-81)

c. To furnish to the Bureau, the Secretary of the U.S. Department of Health and Human Services, the

Fraud Investigation Bureau, or the Department of Law Enforcement, information requested on business transactions as follows: (11-10-81)

i. Ownership of any subcontractor with whom the provider has had business transactions of more than twenty-five thousand dollars (\$25,000) during a twelve (12) month period ending on the date of request; and (11-10-81)

ii. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five (5) year period ending on the date of request. (11-10-81)

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: (11-10-81)

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (11-10-81)

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (11-10-81)

03. Termination of Provider Agreements. Provider agreements may be terminated with or without cause. (3-2-94)

a. The Department may, in its discretion, terminate a provider's agreement for cause based on its conduct or the conduct of its employees or agents, when the provider fails to comply with any term or provision of the provider agreement. Other action may also be taken, based on the conduct of the provider as provided in Section 190, and notice of termination shall be given as provided therein. Terminations for cause may be appealed as a contested case pursuant to the Rules Governing Contested Case Proceedings and Declaratory Ruling, IDAPA 16.05.03.000. et seq. (3-2-94)

b. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the state plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, it shall be twenty-eight (28) days. Terminations without cause may result from, but are not limited to, elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. (3-2-94)

04. Hospital Agreements. In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital which provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, Section 456, "Rules Governing Medicaid Provider Reimbursement." (3-22-93)

05. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity, that: (7-1-97)

a. Fails to meet the qualifications required by rule or by any applicable licensing board; (7-1-97)

b. Has previously been, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R Section 455.101 (10-1-93), in any entity which was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program or has demonstrated an inability to comply

with the requirements related to the provider status for which application is made, including, but not limited to submitting false claims or violating provisions of any provider agreement; (7-1-97)

c. Has failed, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R § 455.101 (10-1-93), in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; or (7-1-97)

d. Employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 040.05.a. through 040.05.c., of this rule. (7-1-97)

041. -- 044. (RESERVED).

045. ELIGIBILITY FOR MEDICAL ASSISTANCE.

Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 01, "Rules Governing Medicaid for Families and Children," and Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," are applicable in determining eligibility for MA. (12-31-91)

046. -- 049. (RESERVED).

050. MEDICAL ASSISTANCE PROCEDURES.

01. Issuance of Identification Cards. When a person is determined eligible for Medical Assistance pursuant to Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 01, "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)," and Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," the Field Office must prepare and issue to that person a temporary identification card valid only for those dates designated on the card. When requested, the Field Office must give providers of medical services eligibility information regarding those persons with temporary cards. (12-31-91)

02. Identification Card Information. An identification card will be issued monthly after the original issuance to each recipient and will contain the following information: (11-10-81)

- a. The names all persons in the household eligible for MA; and (11-10-81)
- b. Each recipient's sex, birthdate, and identification number, including the suffix; and (11-10-81)
- c. The month, day, and year for which the card is valid; and (11-10-81)
- d. For a recipient eligible for dental services, a "D" to so indicate; and (11-10-81)
- e. For a recipient who has another insurance carrier, an asterisk (*) to so indicate. (11-10-81)

03. Information Available for Recipients. The following information will be available at each Field Office for use by each MA recipient: (11-10-81)

- a. The amount, duration and scope of the available care and services; and (11-10-81)
- b. The manner in which the care and services may be secured; and (11-10-81)
- c. How to use the monthly identification card. (11-10-81)
- d. The appropriate billing procedures required by the Department. (11-10-81)

04. Residents of Other States. To the extent possible, the Department is to assist residents from other

states in meeting their medical needs while in Idaho, regardless of whether the request for assistance originates from another state's welfare agency, from the person himself, or from a provider of medical care and services. (1-16-80)

05. Review of Records. (11-10-81)

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Fraud Investigation Bureau have the right to review pertinent records of providers receiving MA payments. (11-10-81)

b. The review of recipients' medical and financial records must be conducted for the purposes of determining: (11-10-81)

i. The necessity for the care; or (11-10-81)

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (11-10-81)

iii. That charges were not in excess of the provider's usual and customary rates; or (11-10-81)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (11-10-81)

c. Refusal of a provider to permit the Department to review MA pertinent records will constitute grounds for: (11-10-81)

i. Withholding payments to the provider until access to the requested information is granted; or (11-10-81)

ii. Suspending the provider's number. (11-10-81)

051. -- 054. (RESERVED).

055. GENERAL PAYMENT PROCEDURES.

01. Hospital or Long Term Care. (11-10-81)

a. If an MA recipient's attending physician orders hospitalization or long term care services, the recipient must present his recipient card to the admission clerk. Where an identification card indicates that a recipient is enrolled in a coordinated care plan, the provider must obtain a referral from the primary care provider. Claims for services provided to recipients designated as participating in coordinated care by other than the primary care provider, without proper referral, will not be paid. (6-1-94)

b. The hospital or long term care facility must submit claims for care and services provided to the MA recipient on claim forms provided by the Department. (11-10-81)

c. The Central Office must process each claim form received and make payments directly to the hospital or long term care facility. (11-10-81)

d. Long term care facilities must request MA payment of the co-insurance portion of charges for Medicare eligible recipients only after the first twenty (20) days of care. (11-10-81)

02. Other Provided Services. (11-10-81)

a. Each recipient may consult a participating physician or provider of his choice for care and services within the scope of MA by presenting his recipient identification card to the provider, subject to restrictions imposed by a participation in a coordinated care plan. (6-1-94)

b. The provider must copy the required information from the identification card from onto the

appropriate claim form. Where the EVS indicates that a recipient is enrolled in a coordinated care plan, the provider must obtain a referral from the primary care provider. Claims for services provided to recipient designated as participating in coordinated care by other than the primary care provider without proper referral, will not be paid.

(6-1-94)

c. Upon providing the care and services to the MA recipient, the provider or his agent must complete the other sections of the appropriate claim form, sign the form, and mail the original of the form to the Central Office.

(11-10-81)

d. The Central Office is to process each claim form received and make payment directly to the provider.

(1-16-80)

e. The Department will not supply the Uniform Billing Form UB-82, Form 1500, and/or American Dental Association (ADA) Attending Dentist's Statement, or their replacements. Claim forms which will be supplied by the Department in order to meet the Department's unique data and billing requirements include Turn Around Documents (TDAs), the State Drug Claim Form, and the Blue Physician Invoice.

(3-22-93)

03. Medicare Procedures. If a MA recipient is Medicare eligible, the provider must secure the necessary supporting Medicare documents from the fiscal intermediaries and attach the documents to the appropriate claim form prior to submission to the Central Office.

(11-10-81)

04. Services Normally Billed Directly to the Patient. If a hospital provides outpatient diagnostic, radiological, or laboratory services, as ordered by the attending physician, and if it is customary for the hospital to bill patients directly for such services, the hospital must complete the appropriate claim form and submit it to the Bureau.

(11-10-81)

056. -- 059. (RESERVED).

060. FEES AND UPPER LIMITS.

01. Inpatient Hospital Fees. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho. Inpatient payments shall not exceed the Upper Payment limit set forth in the Code of Federal Regulations.

(7-1-97)

02. Outpatient Hospital Fees. The Department will not pay more than the combined payments the provider is allowed to receive from the beneficiaries 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.

(7-1-97)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule.

(5-25-93)

b. Maximum payment for outpatient hospital diagnostic radiology procedures will be limited to the blended rate of costs and the Department's established fee schedule specified in IDAPA 16, Title 03, Chapter 10, Subsection 457.02 at the time of cost settlement.

(7-1-97)

c. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule.

(5-5-93)

d. Maximum payment for hospital out-patient surgical procedures will be limited to the blended rate of costs and the Department's fee schedule for ambulatory surgical centers specified in IDAPA 16.03.10, Subsection 457.01 at the time of cost settlement.

(7-1-97)

e. Hospital based ambulance services will be reimbursed according to Medicare cost reimbursement principles. All other ambulance providers will be reimbursed according to the Department's established fee schedule

for medical transportation.

(7-1-97)

03. Long-Term Care Facility Fees. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (11-10-81)

04. Individual Provider Fees. The Department will not pay the individual provider more than the lowest of: (11-10-81)

- a. The provider's actual charge for service; or (11-10-81)
- b. The maximum allowable charge for the service as established by the Department on its pricing file; or (11-10-81)
- c. The Medicare upper limitation of payment on those services where a beneficiary is eligible under both programs and Medicaid is responsible only for the deductible and co-insurance payment. (11-10-81)

05. Fees for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325 and 42 CFR Section 447.352 and Section 1902(a)(13)(E) of the Social Security Act. (7-1-97)

061. -- 064. (RESERVED).

065. SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

The following services are not covered for payment by the Medical Assistance Program: (5-15-84)

- 01. Service Categories Excluded. The following categories of service are excluded from MA payment: (5-15-84)
 - a. Acupuncture services; and (5-15-84)
 - b. Naturopathic services; and (5-15-84)
 - c. Bio-feedback therapy; and (11-10-87)
 - d. Fertility related services including testing. (11-10-87)
- 02. Procedure Excluded. The costs of physician and hospital services for the following types of treatments are excluded from MA payment. This includes both the procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure: (6-1-86)
 - a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; or (6-1-86)
 - b. Cosmetic surgery, excluding reconstructive surgery which has prior approval by the Department; or (6-1-86)
 - c. Acupuncture; or (6-1-86)
 - d. Bio-feedback therapy; or (6-1-86)
 - e. Laetrile therapy; or (6-1-86)
 - f. Organ transplants; lung, pancreas, or other transplants considered investigative or experimental

procedures and multiple organ transplants; or (10-1-91)

g. Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomies. (11-10-87)

h. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and which are excluded by the Medicare program are excluded from MA payment; or (5-15-84)

i. Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 126; or (12-31-91)

j. Examinations: (6-1-86)

i. For routine checkups, other than those associated with the EPSDT program; or (6-1-86)

ii. In connection with the attendance, participation, enrollment, or accomplishment of a program; or (6-1-86)

iii. For employment. (6-1-86)

k. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; or (6-1-86)

l. The treatment of complications, consequences or repair of any medical procedure, in which the original procedure was excluded from MA coverage, unless the resultant condition is life threatening as determined by the MA Section of the Department; or (5-15-84)

m. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service are excluded from MA payment. (5-15-84)

n. Eye exercise therapy. (10-25-88)

o. Surgical procedures on the cornea for myopia. (3-2-94)

066. RECONSTRUCTIVE SURGERY.

Reconstruction or restorative procedures which may be rendered with prior approval by the Department include procedures which restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. (T)

067. -- 068. (RESERVED).

069. SURGICAL PROCEDURES FOR WEIGHT LOSS.

01. Surgery for the Correction of Obesity. Surgery for the correction of obesity is covered only with prior authorization from the Bureau of Medicaid Policy and Reimbursement. Surgical procedures for weight loss will be considered when the patient meets the weight criteria for morbid obesity as defined in Subsection 003.36 of these rules; and, (7-1-97)

a. Is not over age fifty-five (55) and non-diabetic; or, (7-1-97)

b. Is not over age forty-five (45) and is diabetic; and, (7-1-97)

c. Has one (1) of the major life threatening complications of obesity: alveolar hypoventilation, uncontrolled diabetes, or uncontrolled hypertension: (7-1-97)

i. For purposes of this Subsection, "uncontrolled" means that there is inadequate compliance or response to a prescribed medical regimen. (7-1-97)

ii. Other complications of obesity such as orthopedic treatment, skin and wound care are not considered justification for a surgical remedy. (7-1-97)

d. Must have a psychiatric evaluation to determine the stability of personality at least three (3) months prior to date the surgery is requested; (7-1-97)

e. Understands and accepts the resulting risks associated with the surgery. (7-1-97)

02. All Patients Requesting Surgery. All patients requesting surgery must have their physician send a complete history and physical exam, and medical records documenting the patient's weight and efforts to lose weight by conventional means over the past five (5) years for the request to be considered. (7-1-97)

03. The Documentation of Life Threatening Complications. The documentation of life threatening complications in Subsection 069.01.c. of these rules. must be provided by a consultant specializing in pulmonary diseases, endocrinology, or cardiology/hypertensive illness who is not associated by clinic or other affiliation with the surgeons who will perform the surgery, or the primary physician who refers the patient for the procedure. (7-1-97)

04. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered only with prior authorization from the Bureau of Medicaid Policy and Reimbursement. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, the following: (7-1-97)

a. Photographs of the front, side and underside of the patient's abdomen; and, (7-1-97)

b. Documented treatment of the ulceration and skin infections involving the panniculus; and, (7-1-97)

c. Documented failure of conservative treatment, including weight loss; and, (7-1-97)

d. That the panniculus severely inhibits the patient's walking; and, (7-1-97)

e. The client is unable to wear a garment to hold the panniculus up; and, (7-1-97)

f. Other detrimental effects of the panniculus on the patients's health such as severe arthritis in the lower body. (7-1-97)

070. PHYSICIAN SERVICES.

01. Services Provided. The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 065 and Subsection 070.02. All services not specifically included in this chapter are excluded from reimbursement. (12-31-91)

02. Restriction of Coverage. (7-1-93)

a. Out-patient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible recipient in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (11-10-81)

b. Particular restrictions pertaining to payment for sterilization procedures are contained in Section 090; and (12-31-91)

c. Restrictions governing payment for abortions are contained in Section 095; and (12-31-91)

d. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed recipients over the age of forty (40). This limitation does not apply to recipients receiving continuing treatment for glaucoma. (10-25-88)

e. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis; and (11-10-81)

f. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (11-10-81)

g. Corneal transplants and kidney transplants are covered by the MA program. (5-15-84)

03. Misrepresentation of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. (6-1-86)

04. Physician Penalties for Late PRO Review. Medicaid will assess the physician a penalty for failure to have a preadmission review in accordance with Subsection 080.02.a. and Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Provider Reimbursement in Idaho," as amended. A penalty will be assessed according to Subsection 070.05 entitled "Physician Penalty Chart." The assessed penalty will be based on the total Medicaid allowed amount for the physician services for the entire stay after any third party payment has occurred. (3-1-92)

05. Physician Penalty Chart. (3-1-92)

a. A request for preadmission PRO review that is one (1) day late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of five percent (5%) or fifty dollars (\$50). (3-1-92)

b. A request for preadmission PRO review that is two (2) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of ten percent (10%) or one hundred dollars (\$100). (3-1-92)

c. A request for preadmission PRO review that is three (3) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of fifteen percent (15%) or one hundred and fifty dollars (\$150). (3-1-92)

d. A request for preadmission PRO review that is four (4) days late will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty percent (20%) or two hundred dollars (\$200). (3-1-92)

e. A request for preadmission PRO review that is five (5) days late or later will result in a penalty. Medicaid will deduct from the total Medicaid paid amount of the related claim the lesser of twenty-five percent (25%) or two hundred and fifty dollars (\$250). (3-1-92)

06. Physician Excluded from the Penalty. Any physician who provides care but has no control over the admission, continued stay or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. (3-1-92)

07. Procedures for Medicare Cross-over Claims. If a MA recipient is eligible for Medicare, the physician must bill Medicare first for the services rendered to the recipient. (11-10-81)

a. If a physician accepts a Medicare assignment, the payment for the Medicare co-insurance and deductible will be made and forwarded to the physician automatically based upon the EOMB information on the

computer tape which is received from the Medicare Part B Carrier on a weekly basis. (11-10-81)

b. If a physician does not accept a Medicare assignment, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible. (11-10-81)

c. In order for the Department to make payment, the physician must agree to accept the payment from Medicare and Medicaid as payment in full for covered services. (11-10-81)

071. PAYMENT FOR MEDICAL PROCEDURES PROVIDED BY CERTIFIED REGISTERED NURSE ANESTHETISTS, NURSE PRACTITIONERS, NURSE MIDWIVES, AND PHYSICIAN ASSISTANTS.

The Medicaid Program will pay for services provided by certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), and physician assistants (PA), as defined in Subsections 003.11, 003.38, 003.37, and 003.48 and under the following provisions: (7-1-97)

01. Identification of Services. The required services shall be covered under the legal scope of practice as identified by the appropriate State rules of the CRNA, NP, NM, or PA. (7-1-97)

02. Deliverance of Services. The services shall be delivered under physician supervision as required by each program. (11-10-81)

03. Billing of Services. Billing for the services shall be as provided by the CRNA, NP, NM, or PA, and not represented as a physician service. (7-1-97)

04. Payments Made Directly to CRNA. Payments under the fee schedule shall be made directly to the CRNA under the individual provider number assigned to the CRNA. Rural hospitals that qualify for a Medicare exception and employ or contract CRNAs may be reimbursed on a reasonable cost basis (7-1-97)

05. Reimbursement Limits. The Department shall establish reimbursement limits for each service to be delivered by the NP, NM, or PA. Such services shall be reimbursed as either the billed charge or reimbursement limit established by the Department, whichever is less. (7-1-97)

072. -- 074. (RESERVED).

075. PODIATRY.

The Department will reimburse podiatrists for treatment of acute foot conditions. Acute foot conditions, 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. (11-10-81)

076. -- 079. (RESERVED).

080. IN-PATIENT HOSPITAL SERVICES.

01. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services: (11-10-81)

a. Payment is limited to semi-private room accommodations. (11-10-81)

i. The Department must not authorize reimbursement for any part of a private room unless the attending physician orders a private room for the patient because of medical necessity. (11-10-81)

ii. If a patient or the family of a patient desires a private room, the party ordering the private room will be responsible for full payment for the private room. (11-10-81)

b. If a MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

c. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

d. Hospital care associated with noncovered services as contained in Section 065 is excluded from MA payment. (12-31-91)

02. Payment Procedures. The following procedures are applicable to in-patient hospitals: (11-10-81)

a. The patient's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Peer Review Organization (PRO) designated by the Department. PRO review will be governed by provisions of the PRO Provider Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely PRO review as required by Section 080, and as outlined in the PRO Provider Manual as amended, will result in the PRO conducting a late review. After a PRO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Subsection 080.04 entitled "Hospital Penalty Chart." (3-1-92)

i. The hospital must submit claims for care and services provided to the MA recipient on the appropriate claim forms and attach the PRO approval certification for those diagnoses where preadmission approval is required as well as PRO approval certification for any hospital stay with a length of stay which exceeds the 75th percentile for the primary diagnosis (according to Western Regional P.A.S. Length of Stay published by Health Knowledge System). (12-3-90)

ii. Reimbursement for services originally identified as not medically necessary by the PRO will be made if such decision is reversed by the appeals process required in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings." (12-31-91)

iii. Absent the Medicaid recipient's informed decision to incur services deemed unnecessary by the PRO, or not authorized by the PRO due to the negligence of the provider, no payment for denied services may be obtained from the recipient. (12-3-90)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for in-patient hospital care in accordance with the rules set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (12-31-91)

c. If a MA recipient is eligible for Medicare the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

i. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

ii. For all other services, a Medicare EOMB must be attached to the appropriate claim form and submitted to the Bureau for the billing of Medicare co-insurance and deductible charges. (11-10-81)

d. Diagnostic tests and procedures, including laboratory tests, pathological, and x-ray examinations whether provided on an in-patient or an out-patient basis, are reimbursable only if related to the diagnosis and treatment of a covered medical condition. (12-3-90)

e. Only tests or evaluations specifically ordered by a physician will be reimbursed. (12-3-90)

03. Duties of the Designated PRO. The designated PRO shall prepare, distribute and maintain a provider manual. The PRO provider manual shall be distributed by the PRO and periodically updated thereafter. The

manual will include, and is not limited to, the following: (10-1-89)

a. The PRO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (10-1-89)

b. Department selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (10-1-89)

c. A provision that the PRO will mail the hospital a completed certification statement within five (5) days of an approved admission, transfer, or continuing stay. (10-1-89)

d. The method of notice to hospitals of PRO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (10-1-89)

e. The procedures which providers or recipients will use to obtain reconsideration of a denial by the PRO prior to appeal to the Department in accordance with the provisions of Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings." Such requests for reconsideration by the PRO must be made in writing to the PRO within sixty (60) days of the issuance of the "Notice of Non-Certification of Hospital Days." (12-31-91)

04. Hospital Penalty Chart. (3-1-92)

a. A request for a preadmission and/or continued stay PRO review that is one (1) day late will result in a penalty of two hundred and sixty dollars (\$260), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

b. A request for a preadmission and/or continued stay PRO review that is two (2) days late will result in a penalty of five hundred and twenty dollars (\$520), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

c. A request for a preadmission and/or continued stay PRO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars (\$780), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

d. A request for a preadmission and/or continued stay PRO review that is four (4) days late will result in a penalty of one thousand and forty dollars (\$1,040), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

e. A request for a preadmission and/or continued stay PRO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars (\$1,300), from the total Medicaid paid amount of the inpatient hospital stay after any third party payment. (3-1-92)

081. ORGAN TRANSPLANTS.

The Department may purchase organ transplant services for bone marrows, kidneys, hearts, and livers when provided by hospitals approved by the Department. The Department may purchase cornea transplants for conditions where such transplants have demonstrated efficacy. (10-1-91)

01. Heart or Liver Transplants. Heart or liver transplant surgery will be covered only if the procedure is performed in a transplant facility approved for transplant of the heart or liver by the Health Care Financing Administration for the Medicare program and has completed a provider agreement with the Department. (10-1-91)

02. Kidney Transplants. Kidney transplantation surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one (1) of the End Stage Renal Dialysis (ESRD) network area's organizations designated by the Secretary of Health and Human Services for Medicare certification. (10-1-91)

03. Living Kidney Donor Costs. The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (10-1-91)

04. Coverage Limitations. When the need for transplant of a second organ such as a heart, lung, liver, bone marrow, pancreas, or kidney represents the coexistence of significant disease, the organ transplants will not be covered. (10-1-91)

a. Each kidney or lung is considered a single organ for transplant; (10-1-91)

b. Retransplants will be covered only if the original transplant was performed for a covered condition and if the retransplant is performed in a Medicare/Medicaid approved facility; (10-1-91)

c. A liver transplant from a live donor is considered an investigative procedure and will not be covered; (10-1-91)

d. Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered; (10-1-91)

e. Except for cornea transplants, all organ transplants are excluded from MA payment unless preauthorized by the PRO and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. (10-1-91)

05. Noncovered Transplants. Services, supplies, or equipment directly related to a noncovered transplant will be the responsibility of the recipient. (10-1-91)

06. Follow Up Care. Follow up care to a recipient who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation. (10-1-91)

082. -- 084. (RESERVED).

085. OUT-PATIENT HOSPITAL SERVICES.

On site services eligible for payment include preventive, diagnostic, therapeutic, rehabilitative or palliative items, or services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. (3-22-93)

01. Exceptions and Limitations. (7-1-93)

a. Claims for emergency room service must include a diagnosis and copy of the emergency room record. (11-10-81)

b. Payment for emergency room service is limited to six (6) visits per calendar year. (11-10-81)

c. Emergency room services which are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. (11-10-81)

02. Procedures for Medicare Cross-over Claims. (11-10-81)

a. If an MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

b. If the services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

c. For all other services, a Medicare EOMB must be attached to the appropriate claim form and

submitted to the Bureau for the billing of Medicare co-insurance and deductible charges. (11-10-81)

086. -- 089. (RESERVED).

090. FAMILY PLANNING.

Family planning includes counseling and medical services prescribed or performed by an independent licensed physician, or a qualified certified nurse practitioner or physician's assistant. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. (11-10-81)

01. Contraceptive Supplies. (7-1-93)
 - a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (11-10-81)
 - b. Contraceptives requiring a prescription are payable subject to Section 126. (12-31-91)
 - c. Payment for oral contraceptives is limited to purchase of a three (3) month supply. (11-10-81)
 - d. Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (11-10-81)
02. Sterilization Procedures -- General Restrictions. The following restrictions govern payment for sterilization procedures for eligible persons. (11-10-81)
 - a. No sterilization procedures will be paid on behalf of a recipient who is not at least twenty-one (21) years of age at the time he or she signs the informed consent. (11-10-81)
 - b. No sterilization procedures will be paid on behalf of any recipient who is twenty-one (21) years of age or over and who is incapable of giving informed consent. (11-10-81)
 - c. Each recipient must voluntarily sign the properly completed "Consent Form," HW 0034, in the presence of the person obtaining consent (see Subsection 090.03 for requirements). (12-31-91)
 - d. Each recipient must sign the "Consent Form" at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures (see Subsection 090.04 for exceptions). (12-31-91)
 - e. The person obtaining consent must sign the "Consent Form," HW 0034, and certify that he or she has fulfilled specific requirements in obtaining the recipient's consent (see Subsection 090.03 for requirements). (12-31-91)
 - f. The physician who performs the sterilization must sign the "Consent Form," HW 0034, certifying that the requirements of Subsection 090.03 have been fulfilled. (12-31-91)
 - g. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are eligible for payment unless such sterilizations are ordered by a court of law. (11-10-81)
 - h. Hysterectomies performed solely for sterilization purposes are not eligible for payment (see Subsection 090.06 for those conditions under which a hysterectomy can be eligible for payment). (12-31-91)
 - i. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (11-10-81)
 - j. Suitable arrangements must be made to insure that information as specified in Subsection 090.02 is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. (12-31-91)
03. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form," HW 0034, is submitted to the Department together with the physician's claim for the sterilization.

- (11-10-81)
- a. The consent form must be signed and dated by: (1-16-80)
 - i. The MA recipient to be sterilized; and (1-16-80)
 - ii. The interpreter, if one (1) is provided; and (1-16-80)
 - iii. The individual who obtains the consent; and (11-10-81)
 - iv. The physician who will perform the sterilization procedure. (11-10-81)
 - v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (11-10-81)
 - b. Informed consent must not be obtained while the recipient in question is: (11-10-81)
 - i. In labor or childbirth; or (1-16-80)
 - ii. Seeking to obtain or obtaining an abortion; or (1-16-80)
 - iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. (1-16-80)
 - c. An interpreter must be provided if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent. (11-10-81)
 - d. The person obtaining consent must: (11-10-81)
 - i. Offer to answer any questions the recipient may have concerning the procedure; and (11-10-81)
 - ii. Orally advise the recipient that he/she is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting his/her right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and (11-10-81)
 - iii. Provide a description of available alternative methods of family planning and birth control; and (1-16-80)
 - iv. Orally advise the patient that the sterilization procedure is considered to be irreversible; and (11-10-81)
 - v. Provide a thorough explanation of the specific sterilization procedure to be performed; and (11-10-81)
 - vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and (11-10-81)
 - vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and (11-10-81)
 - viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 090.04. (12-31-91)
 - e. The person securing the consent from the recipient must certify by signing the "Consent Form" that: (11-10-81)

- i. Before the recipient signed the consent form, he or she was advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and (11-10-81)
- ii. The requirements for informed consent as set forth on the consent form were orally explained; and (11-10-81)
- iii. To the best of his knowledge and belief, the patient appeared mentally competent and knowingly and voluntarily consented to the sterilization. (11-10-81)
- f. The physician performing the sterilization must certify by signing the "Consent Form" that: (11-10-81)
 - i. At least thirty (30) days have passed between the recipient's signature on that form and the date the sterilization was performed; and (11-10-81)
 - ii. To the best of the physician's knowledge the recipient is at least twenty-one (21) years of age; and (11-10-81)
 - iii. Before the performance of the sterilization the physician advised the recipient that no federal benefits will be withdrawn because of the decision to be or not to be sterilized; and (11-10-81)
 - iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form;" and (11-10-81)
 - v. To the best of his knowledge and belief the recipient to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization. (11-10-81)
- g. If an interpreter is provided, he must certify by signing the "Consent Form" that: (11-10-81)
 - i. He accurately translated the information and advice presented orally to the recipient; and (11-10-81)
 - ii. He read the "Consent Form" and accurately explained its contents; and (11-10-81)
 - iii. To the best of his knowledge and belief, the recipient understood the interpreter. (11-10-81)
- 04. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the recipient's signature on the consent form; and (11-10-81)
 - a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and (11-10-81)
 - b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (11-10-81)
 - c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (11-10-81)
- 05. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization. In addition he must: (11-10-81)
 - a. Certify, by signing a properly completed "Consent Form" and submitting the consent form with his claim, that all requirements have been met concerning sterilizations; and (11-10-81)

- b. Submit to the Department a copy of the court order together with the "Consent Form" and claim. (11-10-81)
- 06. Circumstances Under Which Payment Can Be Made for a Hysterectomy. Payment can be made for a hysterectomy only if: (11-10-81)
 - a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and (11-10-81)
 - b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and (11-10-81)
 - c. The patient was advised orally and in writing that sterility would result and that she would no longer be able to bear children; and (11-10-81)
 - d. The patient signs the "Authorization for Hysterectomy," (HW-0029) or its equivalent, acknowledging receipt of the information. (11-10-81)

091. TARGETED CASE MANAGEMENT FOR PREGNANT PARENTING TEENS AND THEIR INFANTS.

The Department will purchase case management (CM) services for qualified pregnant teens only in specific target areas. Services will be provided by qualified providers who have entered into a provider agreement with the Department. The purpose of these services is to assist targeted individuals to gain access to needed medical, social, educational, vocational and other services to promote positive pregnancy outcomes and develop self-sufficiency. (3-2-94)

01. Target Group. Medicaid eligible pregnant teens seventeen (17) years of age or younger at time of conception. Teens who qualify for case management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until seventy-two (72) hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. (3-2-94)

02. Target Areas. Adams, Washington, Payette, Gem, Canyon and Owyhee counties. (3-2-94)

03. Service Descriptions. Case Management services shall be delivered in accordance with these rules by qualified providers to assist qualified teens/infants in obtaining and coordinating needed health, educational, vocational and social services most appropriate for self-sufficiency. CM services shall consist of the following core functions: (3-2-94)

- a. Assessment. A CM provider must assess the patient/recipient's needs through the systematic collection of data to determine current status and needs. Data sources include, but are not limited to, patient/recipient and family interviews, existing available records, and needs tests. The case manager will identify the patient/recipient's current needs, including but not limited to: (3-2-94)
 - i. Relationship with a primary health care provider; (3-2-94)
 - ii. Immunization status; (3-2-94)
 - iii. History of physical exams; (3-2-94)
 - iv. Family health care utilization practices; (3-2-94)
 - v. Social and health services currently being used by the family; (3-2-94)

- vi. Physical health; (3-2-94)
- vii. Mental health; (3-2-94)
- viii. Academic functioning; (3-2-94)
- ix. Behavior problems; (3-2-94)
- x. Social relationships; (3-2-94)
- xi. Environmental situations; (3-2-94)
- xii. Developmental status; (3-2-94)
- xiii. Mobility capabilities; (3-2-94)
- xiv. Family functioning; (3-2-94)
- xv. Nutritional status and eating disorders; (3-2-94)
- xvi. Chemical use/abuse and tobacco use by individual and presence in environment; (3-2-94)
- xvii. Future family planning needs; and (3-2-94)
- xviii. Other needs as identified by the recipient, and/or family/caretaker. (3-2-94)

b. Development of Plan of Care. Based on the needs assessment, the case manager will develop a plan of care. Planning activities involve making specific decisions regarding the patient/recipient's needs and determining the resources available to meet those needs in a coordinated, integrated fashion. The plan of care will provide for transition to independence, including an expected date and method for achieving such transition. When possible, family members and/or caretakers and appropriate professionals are to be included in the planning process. (3-2-94)

i. Integrated Document. The plan of care is an integrated document which provides the basis for the delivery of services. The plan must be written and identify each problem to be addressed, the expected outcome, the referrals to be made, resources to be used, and identification of responsibilities. (3-2-94)

ii. Review and Update. The case manager and recipient or caretaker will review and update the plan of care as needed, collaborating as necessary with appropriate parties. (3-2-94)

iii. Documentation. The plan of care and accompanied documents serve as documentation for payment purposes. The patient/recipient's record must include the formal plan of care and updates to the plan, and any narrative documentation reflecting active priorities. It should also include an intake assessment, a copy of a completed intake reporting form, and identification of areas where intervention is needed. (3-2-94)

c. Implementation of Plan of Care. Implementation ensures that the recipient and/or family receives services as indicated in the patient/recipient's plan of care. (3-2-94)

i. Referrals. The case manager will make referrals in a coordinated, planned manner or provide information and assist patient/recipient's to self-refer. (3-2-94)

ii. Linking/Coordination of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. (3-2-94)

iii. Advocacy. Related advocacy activities are provided to assist the family to achieve the goals of the plan, particularly when resources are inadequate or the service delivery system is nonresponsive. The case manager will negotiate or otherwise assist the recipient/caretaker in accessing appropriate services. Advocacy may include, but is not limited to: (3-2-94)

(1) Intervening with agencies or persons to help individual recipients receive appropriate benefits or services; and (3-2-94)

(2) Assisting the recipient/caretaker to accomplish necessary tasks such as filling out pertinent forms, obtaining necessary documentation or authorization, and finding transportation to services. (3-2-94)

d. Crisis/Urgent Assistance. Crisis/urgent assistance services are those case management activities that are needed in addition to the assessment, development and implementation of the plan of care resulting from emergency/urgent situations. These are activities to obtain emergency housing, protection of the patient/recipient, to meet health care needs, or similar activities required by the imminence of the situation. Crisis/Urgent assistance may be provided prior to or after the completion of the plan of care. (3-2-94)

04. CM Provider Qualifications. Case management providers must meet the following criteria: (3-2-94)

a. Operate as an organization with on-site ability to provide a comprehensive service package to pregnant teens that includes JOBS counseling, arrangement for child care services, Child Support Services, WIC, immunizations, sexually transmitted disease service, and family planning; (3-2-94)

b. Have at least four (4) years of experience with, and demonstrated positive outcomes in work with, the targeted group; (3-2-94)

c. Have appropriate liability insurance and be responsible for the withholding and payment of taxes for its employees; and (3-2-94)

d. Be located in the target area. (3-2-94)

05. CM Provider Staff Qualifications. Staff members delivering case management services for the provider organization must meet the following qualifications: (3-2-94)

a. Be a registered nurse or a licensed social worker; (3-2-94)

b. Be under the direct supervision of, or a subcontractor of, the provider organization; and (3-2-94)

c. Case manage no more than forty-five (45) individuals at any time. (3-2-94)

06. Recipient's Choice. The qualified patient/recipient will be allowed to choose whether or not she desires to receive CM services. Recipients may also choose the providers of medical and other services under the Medicaid program, subject to restrictions imposed by managed care programs. (3-2-94)

07. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. CM does not include the provision of services such as transportation, psychotherapy or counseling, supportive therapy, or training. Medicaid will reimburse only for core services (Subsection 091.03) provided to members of the target group by qualified staff. (3-2-94)

a. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-2-94)

b. Payment will not be made for CM services provided to individuals who are inpatients in nursing facilities, ICFs/MR, or hospitals. (3-2-94)

c. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. (3-2-94)

d. Reimbursement for the assessment and individual plan of care development for the mother or the child shall be paid based on a one-time flat rate established by the Bureau. (7-1-94)

e. Reimbursement for on-going case management services such as review and revision of the plan of care or crisis management shall be made based on a monthly rate for the calendar months in which at least one face-to-face contact has occurred to render CM services. The rate will be established by the Bureau. (7-1-94)

f. The Department will not provide Medicaid reimbursement for on-going case management services delivered prior to the completion of the assessments and individual plan of care. (3-2-94)

g. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and individual service plan. (3-2-94)

h. Audit reviews may be conducted by the Department. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (3-2-94)

i. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (3-2-94)

j. The provider will provide the Department with access to all information required to review compliance with these rules. (3-2-94)

k. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-2-94)

08. Record Requirements. The following documentation must be maintained by the provider: (3-2-94)

a. A standard plan of care and progress notes which include the following: (3-2-94)

i. Name, age, race, and ethnicity of recipient; (3-2-94)

ii. Name of the provider agency and the case manager providing the service; (3-2-94)

iii. Date, time, and duration of service; (3-2-94)

iv. Place of service; (3-2-94)

v. Activity record describing the recipient and the service provided; (3-2-94)

vi. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management. (3-2-94)

b. Standard forms, including but not limited to: (3-2-94)

i. Intake form; (3-2-94)

ii. Pregnancy outcome forms; (3-2-94)

iii. Tracking forms; and (3-2-94)

iv. Exit forms. The standard forms used by case managers must collect information in the following areas: recipient characteristics; maternity related needs; substance use treatment and education; primary and

preventative health services and education; pediatric care; sexual decision-making; nutrition counseling; adoption counseling; child support enforcement services; educational/vocational training needs; economic/housing needs; role/relationship needs; child care needs; transportation; and consumer/homemaking skills. (3-2-94)

092. -- 094. (RESERVED).

095. ABORTION PROCEDURES.

01. Requirements for Funding Abortions Under Title XIX. The Department will fund abortions under Title XIX only under circumstances where the abortion is necessary to save the life of the woman or in cases of rape or incest as determined by the courts or, where no court determination has been made, if reported to a law enforcement agency. This Subsection is effective retroactively from October 1, 1993. (10-1-93)

02. Requirements for Funding Abortions Solely with State Funds. The Department will fund abortions solely out of state general funds only under circumstances where the abortion is determined to be medically necessary to save the health of the woman. The woman applying for services under this subsection shall apply for and be determined by the Department to be otherwise Medicaid eligible. This Subsection is effective retroactively from February 17, 1994. (2-17-94)

03. Required Documentation for Payment. The following documentation shall be provided: (10-1-93)

a. In the case of rape or incest: (10-1-93)

i. A copy of the court determination of rape or incest must be provided; or (10-1-93)

ii. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency. (10-1-93)

iii. Where the rape or incest was not reported to a law enforcement agency, two (2) licensed physicians must certify in writing that, in the physicians' professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman; or (10-1-93)

iv. Documentation that the woman was under the age of eighteen (18) at the time of sexual intercourse. This Subsection 095.03.a. is effective retroactively from October 1, 1993. (10-1-93)

b. In the case where the abortion is necessary to save the life of the woman, two (2) licensed physicians must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. This Subsection 095.03.b. is effective retroactively from October 1, 1993. (10-1-93)

c. In the case where the abortion is determined to be medically necessary to save the health of the woman, two (2) licensed physicians must certify in writing that the abortion is medically necessary to prevent injury or damage to the health of the woman. The certification must contain the name and address of the woman. This Subsection 095.03.c. is effective retroactively from February 17, 1994. (2-17-94)

096. -- 098. (RESERVED).

099. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICE COORDINATION.

The Department will purchase case management services hereafter referred to as Service Coordination (SC) for Medicaid eligible children age birth to twenty-one (21) years of age who meet medical necessity criteria. (10-1-94)

01. Medical Necessity Criteria. Medical necessity criteria for SC services under EPSDT are as follows: (10-1-94)

a. Children eligible for SC must meet one of the following diagnostic criteria: (10-1-94)

i. Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. (10-1-94)

ii. Children who have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illnesses, or injuries. (5-24-95)

iii. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one year or more. (5-24-95)

b. Children eligible for SC must have one or more of the following problems associated with their diagnosis: (10-1-94)

i. The condition requires multiple service providers and treatments; or (10-1-94)

ii. The condition has resulted in a level of functioning below age norm in one or more life areas, such as school, family, or community; or (10-1-94)

iii. There is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition; or (10-1-94)

iv. There is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or (10-1-94)

v. Further complications may occur as a result of the condition without provision of service coordination services; and (5-24-95)

vi. The family needs a service coordinator to assist them to access medical and other services for the child. (5-24-95)

02. Service Descriptions. SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: (10-1-94)

a. Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. (10-1-94)

b. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. (10-1-94)

c. Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family, and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to

implementation. (5-24-95)

d. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four (24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. (10-1-94)

e. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems. (10-1-94)

03. SC Provider Agency Qualifications. SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: (10-1-94)

a. Demonstrated experience and competency in providing all core elements of service coordination services to children meeting the medical necessity criteria. (5-24-95)

b. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications. (10-1-94)

04. Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: (10-1-94)

a. Must be a licensed M.D., D.O., social worker, R.N., or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria. (5-24-95)

b. Individuals without the one (1) year experience may gain this experience by working for one (1) year under the supervision of an individual who meets the above criteria. (5-24-95)

c. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. (10-1-94)

d. Pass a criminal history background check. (10-1-94)

e. The caseload of service coordinators will be limited to fifty (50) when using one (1) or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. A waiver of the caseload limit may be granted by the Department on a case by case basis and must meet the following criteria: (5-24-95)

i. The availability of service coordinators is not sufficient to meet the needs of the service area; or (5-24-95)

ii. The recipient's family who has chosen the particular service coordinator who has reached his limit, has just cause to need that particular provider over other available providers; or (5-24-95)

iii. The individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) recipients; and (5-24-95)

- iv. The request for waiver must include: (5-24-95)
 - (1) The time period for which the waiver is requested; and (5-24-95)
 - (2) The alternative caseload limit requested; and (5-24-95)
 - (3) Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and safety of any of the service coordinator's consumers. (5-24-95)
 - v. The Department may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of the service coordination services provided. (5-24-95)
05. Recipient's Choice. The eligible child's family, custodian, or legal guardian will be allowed to choose whether or not they desire to receive SC services. All eligible children and their families who choose to receive SC services will have free choice of qualified SC providers as well as the qualified providers of medical and other services under the Medicaid program. (10-1-94)
06. Payment for Services. When a recipient is enrolled in managed care/Healthy Connections, the referral for assessment and services must be authorized by primary care providers. When an assessment indicates the need for medical, advocacy, psychiatric, social, educational, early intervention or other services, referral or arrangement for such services may be included as SC services; however, the actual provision of the service does not constitute SC. Medicaid will reimburse for SC services only when ordered by a physician/nurse practitioner/physician assistant and provided by qualified staff of an approved provider agency or their contractor to eligible children who meet the medical necessity criteria. (5-24-95)
- a. Payment for SC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)
 - b. Payment will not be made for SC services provided to children who are inpatients in nursing facilities or hospitals, other than activities performed within the last thirty (30) days of residence which are directed toward discharge and do not duplicate services included in the facility's content of care. (10-1-94)
 - c. Reimbursement for ongoing SC services shall be paid on a fee for service basis for service delivered. The rate shall be established by the Bureau of Medicaid Policy and Reimbursement. (10-1-94)
 - d. Medicaid reimbursement shall be provided only for the following SC services: (10-1-94)
 - i. Face to face contact between the service coordinator and the eligible child, the child's family members, custodian, legal representative, primary care givers, service providers, or other interested groups or persons; (10-1-94)
 - ii. Telephone contact between the service coordinator and the child, the child's service providers, the child's family members, custodian or legal guardian, primary caregivers, legal representative, or other interested persons. (10-1-94)
 - e. Except for crisis assistance the Department will not provide Medicaid reimbursement for ongoing SC services delivered prior to development of the plan by the Department. (10-1-94)
 - f. Audit reviews will be completed by the Department. (10-1-94)
 - g. Plans must be reviewed, updated as needed and re-authorized by the Department/Contractor at least annually. Documentation of provision of services will be reviewed and progress toward expected outcomes will be evaluated. Documentation of satisfaction with services and supports will be obtained from parents, family and guardians. (10-1-94)
 - h. Failure to provide services for which reimbursement has been received or to comply with these

rules will be cause for recoupment of payments for services, sanctions, or both. (10-1-94)

i. The Department will not provide Medicaid reimbursement for SC services provided to a group of children at the same time. (10-1-94)

j. Medicaid will reimburse for SC services on the same date a child is admitted to a hospital, nursing facility, or other institutional setting, so long as the child is not yet admitted at the time of the service delivery. (10-1-94)

07. Record Requirements. The following documentation must be maintained by the provider: (10-1-94)

a. Name of eligible child; and (10-1-94)

b. Name of provider agency and person providing the service; and (10-1-94)

c. A copy of the current approved SC plan which includes the expected outcomes and objectives and is signed by the child's parents, custodian or legal guardian, and the authorizing representative of the Department; and (10-1-94)

d. Date, time, and duration of service; and (10-1-94)

e. Place of service; and (10-1-94)

f. Activity record describing the child and the service provided; and (10-1-94)

g. Documented review of progress toward each SC service plan goal; and (10-1-94)

h. Documentation from parents, family, and guardians of their satisfaction with services and supports. (5-24-95)

i. A copy of the signed informed consent. (5-24-95)

08. Confidentiality. No personally identifiable information may be released in the absence of written informed consent for release by the child's parent, custodian or legal guardian. (5-24-95)

09. Informed Consent. Informed consent must include an explanation of service coordination and the rights and responsibilities of recipient confidentiality assured through existing state laws and rules. (5-24-95)

100. HEALTH CHECK -- EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT).

Services under Health Check are available to all MA recipients up to and including the month of their twenty-first (21st) birthday. (12-31-91)

01. EPSDT Services. EPSDT services include diagnosis and treatment involving medical care within the scope of MA, as well as dental services, eyeglasses, and hearing aids, and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Idaho Title XIX State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. (1-27-91)

a. The Department will set amount, duration and scope for services provided under EPSDT. (1-27-91)

b. Needs for services discovered during an EPSDT screening which are outside the coverage provided by the rules governing Medical Assistance must be shown to be medically necessary and the least costly means of meeting the recipient's medicaid needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physicians's assistant. (3-22-93)

c. The Department will not cover services for cosmetic, convenience or comfort reasons. (1-27-91)

d. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in these rules specifically as a Medicaid covered service will require preauthorization for medical necessity prior to payment for that service. (8-1-92)

e. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. The additional service must be documented by the attending physician as to why it is medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Bureau of Medicaid Policy and Reimbursement will be required prior to payment. (3-22-93)

f. Those services that have not been shown or documented by the attending physician to be the least costly means of meeting the recipient's medical needs are the responsibility of the recipient. (8-1-92)

02. Well Child Screens. (8-1-92)

a. Periodic medical screens should be completed at the following intervals as recommended by the AAP, Committee in Practice and Ambulatory Medicine, September 1987. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services." EPSDT RN screeners will be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian Health Clinic, or federally qualified health clinic. (7-1-94)

i. One (1) screen at or by age one (1) month, two (2) months, three (3) months, four (4) months, six (6) months and nine (9) months. (8-1-92)

ii. One (1) screen at or by age twelve (12) months, fifteen (15) months, eighteen (18) months, and twenty-four (24) months. (8-1-92)

iii. One (1) screen at or by age three (3) years, age four (4) years and age five (5) years. (8-1-92)

iv. One (1) screen at or by age six (6) years, age eight (8) years, age ten (10) years, age twelve (12) years and age fourteen (14) years. (8-1-92)

v. One (1) screen at or by age sixteen (16) years, age eighteen (18) years and age twenty (20) years. (8-1-92)

vi. One (1) screen at initial program entry, up to the recipient's twenty-first (21st) birthday. (8-1-92)

b. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule in Subsection 100.02.a., and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management". (8-1-92)

i. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. (8-1-92)

ii. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary. (8-1-92)

c. Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and be conducted by qualified professionals. (1-27-91)

d. EPSDT RN screeners will routinely refer all clients to primary care providers. EPSDT clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPSDT RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services (e.g. physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation). Efforts shall be made to assure that routine screening will not be duplicated for children receiving routine medical care by a physician. (3-22-93)

03. Vision Services. (8-1-92)

a. The Department will provide vision screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens, as specified in Subsection 100.02, the vision screen is considered part of the medical screening service, (i.e. eye chart). (8-1-92)

b. The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error as outlined in Section 122. (8-1-92)

c. Each eligible MA recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: (11-10-81)

i. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or (2-15-86)

ii. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (2-15-86)

04. Hearing Aids and Services. The Department will provide hearing screening services according to the recommended guidelines of the AAP. (8-1-92)

a. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens, in accordance with Subsection 100.02, the hearing screen is considered part of the medical screening service. (8-1-92)

b. EPSDT hearing services will pay for audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, in accordance with Section 108, with the following exceptions: (8-1-92)

i. When binaural aids are requested they may be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (8-1-92)

ii. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 108.03.a. through 108.03.d. are met. (8-1-92)

iii. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist. (8-1-92)

05. EPSDT Registered Nurse Screener. A registered nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions: (3-22-93)

a. Can produce proof of completion of the Medicaid Child Health Assessment training course (or equivalent as approved by Medicaid) that: (3-22-93)

i. Prepares the RN to identify the difference between screening, diagnosis and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. (3-22-93)

ii. Includes at least five (5) days didactic instruction in child health assessment, accompanied by a component of supervised clinical practice. (3-22-93)

b. Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or federally qualified health clinic in order to provide linkage to primary care services. The employers must have a signed Medical Provider Agreement and Provider Number. (3-22-93)

c. Has an established agreement with a physician or nurse practitioner for consultation on an as-needed basis. (3-22-93)

06. Private Duty Nursing Service. Private Duty Nursing Service provided by an Idaho licensed nurse to certain eligible children for whom the need for such service has been identified in an EPSDT screen. Private Duty Nursing is one nurse dedicated to one hundred percent (100%) of his time to the care of one (1) recipient at the time Private Duty Nursing service is given. The nursing needs cannot be services that can be performed by a Certified Nursing Assistant as in Section 146, but must be of such a technical nature that the Idaho Nurse Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Professional Nurse, (RN) or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from a visiting nurse (Home Health visit). Private Duty Nursing Service must be authorized by the Bureau of Medicaid Policy and Reimbursement prior to delivery of service. (7-1-94)

a. Services needed must include at least one (1) of the following nursing tasks: (1-27-91)

i. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; or (7-1-94)

ii. The maintenance of volume ventilators including associated tracheotomy care; or (1-27-91)

iii. Tracheotomy and oral pharyngeal suctioning; or (1-27-91)

iv. Maintenance and monitoring of an IV site and administration of IV fluids and/or nutritional supplements which are to be administered on a continuous, or daily basis. (1-27-91)

v. A licensed nursing assessment of the child's health is required prior to the administration of a non-routine medication. Non-routine medication is medication for which the administration and amount given to a patient is subject to the findings of a licensed nurse's assessment. Non-routine medication necessary for a health assessment must be required more frequently than once per day for unstable chronic conditions. The fragile health and medication status are so complex that a certified nurse's aide could not be instructed to assist with medication according to the rules of the Idaho Board of Nursing. (8-1-92)

b. Private Duty Nursing Services may be provided only in the recipient's personal residence or when normal life activities take the recipient outside of this setting. Examples of normal life activities would be those hours a recipient would be outside the home setting to attend school or visit their assessment physician. However, if a recipient requests this service only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: (8-1-92)

i. Licensed Nursing Facilities (NF); and (7-1-94)

ii. Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); and (1-27-91)

iii. Licensed Residential Care Facilities; and (1-27-91)

iv. Licensed professional foster homes; and (1-27-91)

- v. Licensed hospitals; and (1-27-91)
- vi. Public or private school. (1-27-91)
- c. Services delivered must be in a written plan of care, and the plan of care must: (1-27-91)
 - i. Include all aspects of the medical, licensed, and personal care services necessary to be performed, including the amount, type, and frequency of such service; and (1-27-91)
 - ii. Must be approved and signed by the attending physician; and (1-27-91)
 - iii. Must be revised and updated as recipient's needs change, but at least quarterly, and must be submitted to the Medicaid Program. (7-1-94)
- d. Physician responsibilities: (1-27-91)
 - i. Provide the Department the necessary medical information in order to establish the recipient's medical eligibility for services based on an EPSDT medical screen. (1-27-91)
 - ii. Order all services to be delivered by the private duty nurse. (1-27-91)
 - iii. Sign and date all orders, and the recipient's care plan. (1-27-91)
 - iv. Update recipient's care plan quarterly, sign and record date of plan approval. (7-1-94)
 - v. Determine if the combination of Private Duty Nursing Services along with other community resources are sufficient to ensure the health or safety of the recipient. If it is determined that the resources are not sufficient to ensure the health and safety of the recipient, notify the family and the Department and assist in placement of the recipient in the appropriate medical facility. (1-27-91)
- e. Nurse responsibilities: (1-27-91)
 - i. Notify the physician immediately of any significant changes in the recipient's physical condition or response to the service delivery. (1-27-91)
 - ii. Notify the Bureau of Medicaid Policy and Reimbursement within forty-eight (48) hours of any changes in the recipient's condition or if the recipient is hospitalized at any time. Failure to submit such notification will result in recoupment of payment for private duty nursing services. (7-1-94)
 - iii. Evaluate changes of condition. (1-27-91)
 - iv. Provide services in accordance with the physician's plan of care. (1-27-91)
 - v. Records are to be maintained in the recipient's home. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. Records of care must include: (8-1-92)
 - (1) The date. (1-27-91)
 - (2) Time of start and end of service delivery. (1-27-91)
 - (3) Comments on client's response to services delivered. (1-27-91)
 - (4) Nursing assessment of recipient's status and any changes in that status per each working shift. (8-1-92)
 - (5) Services provided during each working shift. (8-1-92)

vi. In the case of L.P.N. providers, document that oversight of services by an R.N. is in accordance with the Idaho Nurse Practice Act and the Rules and Policies of the Idaho Board of Nursing. (1-27-91)

vii. Notify the physician if the combination of Private Duty Nursing Services along with other community resources are not sufficient to ensure the health or safety of the recipient. (1-27-91)

f. Case redetermination for Private Duty Nursing: (8-1-92)

i. Redetermination will be at least quarterly. Each recipient's medical records will be reviewed by the Bureau of Medicaid Policy and Reimbursement for medical necessity criteria found in Section 100. (7-1-94)

ii. The purpose of redetermination for Private Duty Nursing is to safeguard against unnecessary care and services and to determine that the care being provided is medically necessary and safe and effective in the home setting. (8-1-92)

g. Factors assessed for redetermination: (8-1-92)

i. That the recipient can and is being maintained in their personal residence and receive safe and effective services through Private Duty Nursing services. (8-1-92)

ii. That recipient's receiving Private Duty Nursing services have medical justification and physician's orders. (8-1-92)

iii. That there is an updated written plan of care, signed by the attending physician. (8-1-92)

iv. That the attending physician has determined the number of Private Duty Nursing hours needed to ensure the health and safety of the recipient in his home. (8-1-92)

v. That all Private Duty Nursing services are provided according to Subsection 100.05.b. (8-1-92)

vi. That the service or services being provided include at least one of the nursing tasks outlined in Subsections 100.05.a.i. through 100.05.a.iv. (8-1-92)

h. Provide responsibilities for Private Nursing redetermination: (8-1-92)

i. To submit a current plan of care to the Bureau of Medicaid Policy and Reimbursement at least quarterly or as the recipient's needs change. Failure to submit an updated plan of care to the Bureau prior to the end date of the last authorization will cause payments to cease until completed information is received and evaluated and authorization given for further Private Duty Nursing services. The plan of care must include all requested material outlined in Subsection 100.05.c. (7-1-94)

ii. To inform the Bureau of Medicaid Policy and Reimbursement within ten (10) calendar days of any changes in service needed by the recipient which qualify that recipient for Private Duty Nursing services. The Bureau must receive notification within ten (10) calendar days. Failure to report these changes in patient status will result in the recoupment of funds paid to the Private Duty Nursing provider. (8-1-92)

i. Nonmedical transportation, such as to the grocery store, is not reimbursable by the Medicaid Program. Medical transportation of the recipient, such as to a physician's office, is not a covered service under the Private Duty Nursing Program but may be covered under the transportation section of the Medicaid Program. (1-27-91)

07. Nutritional Services. Nutritional services include intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment is made at a rate established in accordance with Subsection 060.04. Nutrition services: (12-31-91)

- a. Must be discovered by the screening services and ordered by the physician; and (1-27-91)
- b. Must be medically necessary; and (1-27-91)
- c. Must not be due to obesity; and (1-27-91)
- d. If over two (2) visits per year are needed, must be authorized by the Medicaid Program prior to the delivery of additional visits. (1-27-91)
- 08. Drugs. Drugs not covered by the Idaho Medicaid Program: (1-27-91)
 - a. Must be discovered as being medically necessary by the screening services; and (1-27-91)
 - b. Must be ordered by the attending physician; and (1-27-91)
 - c. Must be authorized by the Medicaid Program prior to purchase of the drug. (1-27-91)
- 09. Oxygen and Related Equipment. Oxygen and related equipment are subject to Subsections 107.01.a., 107.01.b., and 107.01.d. and Subsections 107.04 and 107.05 except when discovered during screening services; physician ordered and meet the following requirements: (8-1-92)
 - a. Oxygen services, PRN or as ordered on less than a continual basis, will be authorized for six (6) months following receipt of medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration and an estimate of the frequency and duration of use. (8-1-92)
 - b. Portable oxygen systems may be covered to complement a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. (1-27-91)
 - c. Laboratory evidence of hypoxemia is not required. (1-27-91)

101. SPECIAL SERVICES RELATED TO PREGNANCY.

When ordered by the patient's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the 60th day following delivery occurs. (1-3-89)

- 01. Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. A single payment for each month of service provided is made at a rate established in accordance with Subsection 060.04. (12-31-91)
- 02. Individual and Family Social Services. Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment at a rate established under the provisions of Subsection 060.04 is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the rules of the Board of Social Work Examiners. (12-31-91)
- 03. Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available at a rate established under the provisions of Subsection 060.04. (12-31-91)
- 04. Nursing Services. Home visits by a registered nurse to assess the client's living situation and

provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided. Payment is made at a rate established in accordance with Subsection 060.04. (12-31-91)

05. Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. Payment is made at a rate established in accord with Subsection 060.04. (12-31-91)

06. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. Such payment is made at rates established in accord with Subsection 060.04 to the qualified providers established in Section 102. (12-31-91)

102. QUALIFIED PROVIDERS OF PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.

The Department will enter into provider agreements allowing presumptive eligibility determination with providers meeting the qualifications of Section 1920(b)(2)(d) of the Social Security Act, and who employ individuals who have completed a course of training supplied by the Department. (1-3-89)

103. (RESERVED).

104. HOSPICE.

Medical assistance will provide payment for hospice services for eligible recipients. Reimbursement will be based on Medicare program coverage as set out in this section. (10-24-88)

01. Definitions. Inherent in these definitions is that a patient understands the nature and basis for eligibility for hospice care without an inappropriate and explicit written statement about how the impending death will affect care. Though only written acknowledgment of the election periods is mandated, it is required that the patient or their representative be fully informed by a hospice before the beginning of a recipient's care about the reason and nature of hospice care. (10-24-88)

a. Attending physician. A physician who: (10-24-88)

i. Is a doctor of medicine or osteopathy; and (10-24-88)

ii. Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. (10-24-88)

b. Benefit period. A period of time that begins on the first day of the month the recipient elects hospice and ends on the last day of the eleventh successive calendar month. (10-24-88)

c. Bereavement counseling. Counseling services provided to the individual's family after the individual's death. (10-24-88)

d. Cap amount. The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid recipients per Subsection 104.12. (12-31-91)

e. Cap period. The twelve (12) month period beginning November 1 and ending October 31 of the next year. See overall hospice reimbursement cap referred to in Subsection 104.12. (12-31-91)

f. Election period. One of eight (8) periods within the benefit period which an individual may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. (10-24-88)

g. Employee. An individual serving the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice

unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice. (10-24-88)

h. Freestanding hospice. A hospice that is not part of any other type of participating provider. (10-24-88)

i. Hospice. A public agency or private organization or a subdivision thereof that: (10-24-88)

i. Is primarily engaged in providing care to terminally ill individuals; and (10-24-88)

ii. Meets the conditions specified for certification for participation in the Medicare and Medicaid programs and has a valid provider agreement. (10-24-88)

j. Independent Physician. An attending physician who is not an employee of the hospice. (10-24-88)

k. Representative. A person who is, because of the individual's mental or physical incapacity, legally authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual. (10-24-88)

l. Social Worker. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. (10-24-88)

m. Terminally Ill. When an individual has a certified medical prognosis that his or her life expectancy is six (6) months or less per Subsection 104.02. (12-31-91)

02. Physician Certification. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures: (10-24-88)

a. For the first period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has one). The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (10-24-88)

i. In the event the recipient's medical prognosis or the appropriateness of hospice care is questionable, the Department has the right to obtain another physician's opinion to verify a recipient's medical status. (10-24-88)

b. For any subsequent election period, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (10-24-88)

c. The hospice must maintain the monthly certification statements for review per Section 190, governing surveillance and utilization. (12-31-91)

d. The hospice will submit a physician listing with their provider application and update changes in the listing of physicians which are hospice employees, including physician volunteers, to the Bureau. The designated hospice must also notify the Medicaid program when the designated attending physician of a recipient in their care is not a hospice employee. (8-1-92)

03. Election Procedures. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election statement may also be filed by a legal representative or guardian per Section 15-5-312, Idaho Code. (10-24-88)

a. An election to receive hospice care will be automatically renewed after the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of a designated hospice and does not revoke the election. (10-24-88)

b. A recipient who elected less than eight (8) monthly election periods within the benefit period may request the availability of the remaining election periods. When the following conditions are met, the request will be granted. (10-24-88)

i. The hospice days available did not exceed two hundred ten (210) days in the benefit period due to the loss of financial eligibility. (10-24-88)

ii. The recipient or the legal representative did not change hospices excessively per Subsection 104.06.a. (7-1-94)

iii. The recipient or the legal representative did not revoke hospice election periods more than eight (8) times per Subsection 104.05. (7-1-94)

c. An individual may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a recipient cannot designate an effective date that is earlier than the date that the election is made. (7-1-94)

d. A recipient must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exceptions: (10-24-88)

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the recipient. (10-24-88)

ii. Any Medicaid services that are not related or equivalent to the treatment of the terminal condition or a related condition for which hospice care was elected. (10-24-88)

iii. Physician services provided by the individual's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (10-24-88)

04. Election of Hospice. The election statement must include the following items of information: (10-24-88)

a. Identification of the particular hospice that will provide care to the individual. (10-24-88)

b. The individual's or representative's acknowledgment that he or she has been given a full understanding of hospice care. (10-24-88)

c. The individual's or representative's acknowledgment that he or she understands that all Medicaid services except those identified in Subsection 104.03.d. are waived by the election during the hospice benefit period. (7-1-94)

d. The effective date of the election. (10-24-88)

e. The signature of the individual or the representative and the date of that signature. (10-24-88)

05. Revocation of Hospice Election. An individual or representative may revoke the election of hospice care at any time. (10-24-88)

a. To revoke the election of hospice care, the individual must file a signed statement with the hospice that includes the following: (10-24-88)

i. The individual revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. (10-24-88)

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. (10-24-88)

06. Change of Hospice. An individual may at any time change their designated hospice during election periods for which he or she is eligible. (10-24-88)

a. An individual may change designated hospices no more than six (6) times during the hospice benefit period. (10-24-88)

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file during the monthly election period, with the hospice from which he or she has received care and with the newly designated hospice, a dated and signed statement that includes the following information: (10-24-88)

i. The name of the hospice from which the individual has received care; (10-24-88)

ii. The name of the hospice from which he or she plans to receive care; and (10-24-88)

iii. The effective date of the change in hospices. (10-24-88)

c. A change in ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part. (10-24-88)

07. Requirements for Coverage. To be covered, a certification that the individual is terminally ill must have been completed as set forth in Subsection 104.02 and hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. The individual must elect hospice care in accordance with Subsection 104.03 and a plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. (7-1-94)

a. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. At least one (1) of the persons involved in developing the initial plan must be a nurse or a physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment, input may be provided by telephone. (10-24-88)

08. Required Services. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of the service. The following services are required: (10-24-88)

a. Nursing care provided by or under the supervision of a registered nurse. (10-24-88)

b. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. (10-24-88)

c. Physician's services performed by a physician as defined in Subsection 104.01.a. (7-1-94)

d. Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. (10-24-88)

e. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a NF that additionally meets the hospice standards regarding staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.

Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. (7-1-94)

f. Medical equipment and supplies include drugs and biologicals. Only drugs as defined in Subsection 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness are required. Appliances include durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include only those that are part of the written plan of care. (7-1-94)

g. Home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. (10-24-88)

h. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. (10-24-88)

i. Nursing care, physician's services, medical social services, and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted for during periods of peak patient loads and to obtain physician specialty services. (10-24-88)

09. Hospice Reimbursement--General. With the exception of payment for physician services (see Subsection 104.11), Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. The four (4) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. (7-1-94)

a. A description of the payment for each level of care is as follows: (10-24-88)

i. Routine home care. The hospice will be paid the routine home care rate for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. (10-24-88)

ii. Continuous home care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day. (10-24-88)

iii. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate. (10-24-88)

iv. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general inpatient care except as described in Subsection 104.11. (7-1-94)

b. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is

to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. (10-24-88)

c. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients. (10-24-88)

d. Obligation of continuing care. After the recipient's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that recipient's care until the patient expires or until the recipient revokes the election of hospice care. (10-24-88)

10. Limitation on Payments for Inpatient Care. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice or its contracted agent(s). (10-24-88)

a. For purposes of computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows: (10-24-88)

i. The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). (10-24-88)

ii. If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed in Subsection 104.10.a., then no adjustment is made. (7-1-94)

iii. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Subsection 104.10.a., then the payment limitation will be determined by: (7-1-94)

(1) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. (10-24-88)

(2) Multiplying excess inpatient care days by the routine home care rate. (10-24-88)

(3) Adding the amounts calculated in Subsections 104.10.a.iii.(1) and 104.10.a.ii.(2). (10-24-88)

(4) Comparing the amount in Subsection 104.10.a.iii.(3) with interim payments made to the hospice for inpatient care during the "cap period." (10-24-88)

b. The amount by which interim payments for inpatient care exceeds the amount calculated as in Subsection 104.10.a.iii.(4) is due from the hospice. (7-1-94)

11. Payment for Physician Services. The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. (10-24-88)

a. Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount per Subsection 104.12 has been

exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. (7-1-94)

b. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: (10-24-88)

i. A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay. (10-24-88)

ii. Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount per Subsection 104.12 has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or X-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice. (7-1-94)

12. Cap on Overall Reimbursement. Aggregate payments to each hospice will be limited during a hospice cap period per Subsection 104.01.e. The total payments made for services furnished to Medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. (7-1-94)

a. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. (10-24-88)

b. "Total payment made for services furnished to Medicaid recipients during this period" means all payments for services rendered during the cap year, regardless of when payment is actually made. (10-24-88)

c. The "cap amount" is calculated by multiplying the number of recipients electing certified hospice care during the period by six thousand five hundred dollars (\$6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics. It will also be adjusted as per Subsection 104.13. (7-1-94)

d. The computation and application of the "cap amount" is made by the Department after the end of the cap period. (10-24-88)

e. The hospice will report the number of Medicaid recipients electing hospice care during the period to the Department. This must be done within thirty (30) days after the end of the cap period as follows: (10-24-88)

i. If the recipient is transferred to a noncertified hospice no payment to the noncertified hospice will be made and the certified hospice may count a complete recipient benefit period in their cap amount. (10-24-88)

f. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days falling within each cap period would be used. (10-24-88)

13. Adjustment of the Overall Cap. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a recipient's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the recipient during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. (6-23-89)

a. After each cap period has ended, the Department will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program. (10-24-88)

- b. Each hospice's cap amount will be computed as follows: (10-24-88)
- i. The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period". (6-23-89)
- ii. The proportion determined in Subsection 104.13.b. for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the recipient first elected hospice. (7-1-94)
- c. The recipient must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing Medicaid recipient during the current cap year. (6-23-89)
14. Additional Amount for NF Residents. An additional per diem amount will be paid for "room and board" of hospice residents in a certified NF receiving routine or continuous care services. In this context, the term "room and board" includes, but is not limited to, all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in Subsections 104.10 and 104.12. The room and board rate will be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the recipient was a resident of that facility. (7-1-94)
15. Post Eligibility Treatment of Income. Where an individual is determined eligible for MA participation in the cost of long term care, the Department must reduce its payments for all costs of the hospice benefit, including the supplementary amounts for room and board, by an amount determined according to Subsection 160.03 of this rule. (7-1-97)

105. HOME HEALTH SERVICES.

01. Care and Services Provided. Home health services encompass services ordered by the patient's attending physician as a part of a plan of care, which include nursing services, home health aide, physical therapy and occupational therapy. (4-1-91)
- a. All plans of care must be reviewed by the patient's physician at least every sixty (60) days; and (11-10-81)
- b. The need for medical supplies and equipment ordered by the patient's physician as required in the care of the patient and suitable for use in the home must be reviewed at least once every sixty (60) days. (7-15-87)
- c. Home health visits are limited to one hundred (100) visits per calendar year per person. (11-10-81)
- d. Payment by the Department for home health services will include mileage as part of the cost of the visit. (11-10-81)
02. Provider Eligibility. In order to participate as a Home Health Agency (HHA) provider for Medicaid eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification will be cause for termination of Medicaid provider status. (7-15-87)
03. Payment Procedures. Payment for home health services will be limited to the services authorized in Subsection 105.01 and must not exceed the lesser of reasonable cost as determined by Medicare or the Title XIX percentile cap. (12-31-91)
- a. For visits performed in the first state fiscal year for which this subsection is in effect, the Title XIX percentile cap will be established at the seventy fifth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Bureau on June 1, 1987. Thereafter the percentile cap will be revised annually, effective at the beginning of each state fiscal year. Revisions will be made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days

prior to the effective date. (8-1-92)

b. When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the patient the total rental cost of a Durable Medical Equipment (DME) item shall not exceed one-twelfth (1/12) of the total purchase price of the item. A minimum rental rate of fifteen dollars (\$15) per month is allowed on all DME items. (5-1-92)

c. The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment. (11-10-81)

d. The Department will not pay for services at a cost in excess of prevailing Medicare rates. (11-10-81)

e. If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and co-insurance amounts which the Department will pay. (11-10-81)

106. DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.

The Department will purchase or rent medically necessary durable medical equipment and medical supplies for recipients residing in community settings. It will also purchase or rent equipment and supplies provided as a part of a home health agency plan of care and which meet the requirements found in Subsections 105.01 and 105.02. No payment will be made for any recipient's DME or medical supplies while such an individual is an inpatient in a hospital NF, or ICF/MR facility as such items are included in the per diem payment. (10-22-93)

01. Required Physician Orders. DME/medical supplies will be purchased only if ordered in writing by a physician with all of the following information written on the Department's designated form or other approved document. Such information must be attached to, or on file with, the Department for each claim submitted prior to payment authorization: (10-1-91)

a. The recipient's medical diagnosis and the current information on the medical condition which requires the use of the supplies and/or medical equipment; and (10-1-91)

b. An estimate of the time period that the medical supply item will be necessary and frequency of use. As needed (PRN) orders shall not be accepted; and (10-1-91)

c. The signature of the prescribing physician and the date of the order; and (11-1-86)

d. For medical supplies, the type and quantity of supplies necessary must be identified; and (11-1-86)

e. A full description of the medical equipment requested. All modifications to a basic equipment item shall be supported by the attending physician's prescription; and (10-1-91)

f. The number of months the equipment will be needed and the recipient's prognosis; and (10-1-91)

g. Oxygen and oxygen-related equipment require additional information (see Section 107). (12-31-91)

02. Program Requirements -- DME. All claims for durable medical equipment must be prior authorized by the Department, except for the following items: (10-1-91)

a. Items which do not require prior authorization have a charge of one hundred dollars (\$100) or less and include the following: (10-31-89)

i. Walkers, canes and crutches; and (10-31-89)

ii. Grab bars, toilet seat extenders and hand-held showers; and (10-31-89)

iii. Sliding boards and bath benches/chairs; and (10-31-89)

- iv. Equipment for the treatment of decubitus ulcers as listed in Subsection 106.02.f.xviii. (10-22-93)
- b. Equipment will be rented unless the Department decides that it would be more cost effective to purchase it. All rentals require prior authorization by the Department. (10-22-93)
- c. Rental payments, including intermittent payments, shall automatically be applied to the purchase of the equipment. When rental payments equal the purchase price of the equipment, ownership of the equipment shall pass to the Department. (10-1-91)
- d. No reimbursement will be made for the cost of materials covered under the manufacturer's warranty. If the warranty period has expired, information on file must include the date of purchase and warranty period. In addition, the Department shall require the following minimum warranty periods: (10-1-91)
 - i. A power drive wheelchair shall have a one (1) year warranty period; (10-22-93)
 - ii. An ultra light wheelchair shall have a lifetime warranty period; (10-22-93)
 - iii. An active duty lightweight wheelchair shall have a five (5) year warranty period; (10-22-93)
 - iv. All other wheelchairs shall have a one (1) year warranty period; (10-22-93)
 - v. All electrical components and new or replacement parts shall have a six (6) month warranty period; (10-1-91)
 - vi. All other DME not specified above shall have a one (1) year warranty period; (10-1-91)
 - vii. If the manufacturer denies the warranty due to user misuse/abuse, that information shall be forwarded to the Department at the time of the request for repair or replacement; (10-1-91)
 - viii. The monthly rental payment shall include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment is the responsibility of the provider. (10-22-93)
- e. Any equipment purchased will remain the property of the Department and return of the equipment to the Department may be required at such time as: (11-1-86)
 - i. The recipient is no longer eligible for MA; or (11-1-86)
 - ii. The recipient no longer requires the use of the equipment; or (11-1-86)
 - iii. The recipient expires. (10-1-91)
- f. Covered equipment is limited to the following listed items: (11-1-86)
 - i. Apnea or cardiac monitors/alarms; and (11-1-86)
 - ii. CPAP machines; and (10-29-92)
 - iii. Commode chairs and toilet seat extenders; and (11-1-86)
 - iv. Crutches and canes; and (11-1-86)
 - v. Electronic bone growth stimulators; and (11-1-86)
 - vi. Equipment used for home dialysis including necessary water treatment equipment; and (11-1-86)
 - vii. Grab bars for the bathroom adjacent to the toilet and/or bathtub; and (11-1-86)

- viii. Hand-held showers; and (11-1-86)
- ix. Home blood glucose monitoring equipment; and (11-1-86)
- x. Hospital beds, mattresses, trapeze bars, and side rails; and (11-1-86)
- xi. Intravenous infusion pumps, insulin infusion pumps, and/or NG tube feeding pumps; and (10-31-89)
- xii. IPPB machines, hand-held nebulizers and manual or electric percussors; and (10-31-89)
- xiii. Oxygen concentrators; and (11-1-86)
- xiv. Pacemaker monitors; and (11-1-86)
- xv. Respirators, compressors and breathing circuit humidifiers; and (11-1-86)
- xvi. Sliding boards and bath benches/chairs; and (11-1-86)
- xvii. Suction pumps; and (11-1-86)
- xviii. Equipment for the treatment or prevention of decubitus ulcers, such as foam or gel pads, sheep skins, etc.; and (11-1-86)
- xix. Transcutaneous and/or neuromuscular electric nerve stimulators; and (11-1-86)
- xx. Walkers; and (11-1-86)
- xxi. Wheelchairs, manual and electric; and (10-31-89)
- xxii. Electric or hydraulic patient lift devices designed to transfer a person to and from bed or bathtub, but excluding lift chairs, devices attached to motor vehicles and wall-mounted chairs which lift persons up and down stairs; and (10-31-89)
- xxiii. Bilirubin lights; and (10-31-89)
- xxiv. Medically necessary protective head gear; and (10-31-89)
- xxv. Home traction equipment; and (10-31-89)
- xxvi. Daily medication dose organizer. (10-31-89)
- g. The total monthly rental cost of a DME item shall not exceed one-twelfth (1/12) of the total purchase price of the item. A minimum rental rate of fifteen dollars (\$15) per month is allowed on all DME items. (10-1-91)
- 03. Coverage Conditions. Coverage of the following items is limited to the circumstances identified: (10-1-91)
 - a. The Department will provide the least costly wheelchair which is appropriate for the recipient's medical needs. The Department will authorize one (1) wheelchair per recipient not more often than once every five (5) years in accordance with the following criteria: (10-1-91)
 - i. In addition to the physician's information, each request for a wheelchair must be accompanied by a written evaluation by a physical therapist or an occupational therapist which includes documentation of the appropriateness and cost effectiveness of the wheelchair and its ability to meet the recipient's long-term medical

- needs; (10-1-91)
- ii. Wheelchairs will be authorized according to the following criteria: (10-1-91)
- (1) A manual wheelchair will be authorized based on the recipient's medical need. The recipient must be nonambulatory or have severely limited mobility and require a mobility aid to participate in normal daily activities; (10-1-91)
- (2) A standard wheelchair will be authorized if the recipient's condition is such that the alternative would be confinement to a chair or bed; (10-1-91)
- (3) A standard lightweight wheelchair will be authorized if the recipient's condition is such that he cannot propel a standard weight wheelchair and the alternative would be confinement to a chair or bed; (10-1-91)
- (4) An ultra light weight wheelchair will be authorized if the recipient's conditions are such that he cannot propel a lightweight or standard weight wheelchair, and it is a last resort before considering a power driven wheelchair. (10-29-92)
- b. Electric wheelchairs are purchased only if the recipient's medical needs cannot be met by a less costly means of mobility. The attending physician must certify that the power drive wheelchair is a safe means of mobility for the recipient and all of the following criteria are met: (10-1-91)
- i. The recipient is permanently disabled as indicated by the attending physician; and (11-1-86)
- ii. The disability is identified by the physician to be such that because of severe upper extremity weakness or lack of function, the recipient cannot operate any manual wheelchair. (10-1-91)
- c. The Department will authorize repairs or the replacements of parts for wheelchairs including, but not limited to, the replacement of tires, footplates, seating systems, drive belts, and joysticks. The Department will repair or replace any of the above listed parts no more than once every twelve (12) months. In addition, nonemergency repairs totaling over two hundred dollars (\$200) for manual wheelchairs and five hundred dollars (\$500) for electric wheelchairs will require the submission of three (3) bids before authorization for payment can be approved. (10-22-93)
- d. Specially designed seating systems for wheelchairs shall not be replaced more often than once every five (5) years. In addition, seating systems for recipients in expected growth stages shall provide for the enlargement of the system without the complete replacement of the system. (10-1-91)
- e. Electric blood glucose testing devices are purchased only when: (11-1-86)
- i. The recipient's eyesight is impaired to the point that color change in standard blood testing strips cannot be accurately detected; and (11-1-86)
- ii. Such eyesight impairment is documented by the attending physician; or (10-31-89)
- iii. The recipient's mental status is such that the recipient cannot be relied upon to accurately interpret test tape/tablet results as documented by the attending physician. (10-31-89)
- iv. When there is medical documentation from the attending physician of insulin dependence with widely fluctuating blood sugars before meal time and/or frequent episodes of insulin reactions and/or evidence of frequent significant ketosis. (10-1-91)
- v. When gestational diabetes has been documented by the attending physician and frequent monitoring of blood sugars is essential to adequately manage blood sugars during pregnancy. (10-1-91)
- f. Electronic pain suppression/muscle stimulation devices are purchased only when the effectiveness of such devices is documented by the physician following a maximum of two (2) month trial period. The limitations

of Subsection 106.03 apply. (10-22-93)

g. Electric hospital beds are purchased or rented only in the following circumstances: (10-31-89)

i. The physician certifies that the recipient's medical condition is such that he is unable to operate a manual hospital bed; and (10-31-89)

ii. The client is unable to change position as needed without assistance; and (10-22-93)

iii. The recipient resides in an independent living situation where there is no one to provide assistance with a manual bed for the major portion of the day. (10-31-89)

h. Continuous positive airway pressure (CPAP) machines are purchased or rented only in the following circumstances: (10-29-92)

i. The physician certifies that the recipient's diagnosis is obstructive sleep apnea, which is supported by documentation of at least thirty (30) episodes of apnea, each lasting a minimum of twenty (20) seconds during six (6) to seven (7) hours of recorded sleep; and (10-29-92)

ii. Surgery is a likely alternative. (10-29-92)

i. Bilevel positive airway pressure (BiPAP) are purchased or rented only in the following circumstances: (10-22-93)

i. A CPAP machine has been proven ineffective in treating obstructive sleep apnea; and/or (10-22-93)

ii. Used in place of a ventilator. (10-22-93)

04. Program Requirements -- Medical Supply Items. The Department will purchase a one (1) month supply of necessary medical supplies for the treatment or amelioration of a medical condition identified by the attending physician in an amount not to exceed one hundred dollars (\$100) per month without prior authorization. Any combination of one (1) month's worth of supplies greater than one hundred dollars (\$100) requires prior authorization. Each of the claims for the preceding must contain all information required in Subsection 106.01. The prior authorization period will be established by the Department following receipt of a physician's order and medical justification. (10-22-93)

a. Covered supplies are limited to the following: (11-1-86)

and i. Catheter supplies including catheters, drainage tubes, collection bags, and other incidental supplies; (11-1-86)

ii. Cervical collars; and (11-1-86)

iii. Colostomy and/or urostomy supplies; and (11-1-86)

iv. Disposable supplies necessary to operate Department approved medical equipment such as suction catheters, syringes, saline solution, etc.; and (11-1-86)

v. Dressings and bandages to treat wounds, burns, or provide support to a body part; and (11-1-86)

vi. Fluids for irrigation; and (11-1-86)

vii. Incontinence supplies (See Subsection 106.04.c. for limitations); and (10-22-93)

viii. Injectable supplies including normal saline and Heparin but excluding all other prescription drug items; and (10-31-89)

- ix. Blood glucose or urine glucose checking/monitoring materials (tablets, tapes, strips, etc.); and (10-31-89)
- x. Therapeutic drug level home monitoring kits. (10-31-89)
- b. Oral, enteral, or parenteral nutritional products of any amount must be prior authorized by the Department. The Department will only consider authorization under the following circumstances: (10-1-91)
 - i. A nutritional plan shall be developed and be on file with the Department and shall include appropriate nutritional history, the recipient's current height, weight, age and medical diagnosis. For recipients under the age of twenty-one (21), a growth chart including weight/height percentile shall be included; (10-1-91)
 - ii. The plan shall include goals for either weight maintenance and/or weight gain and shall outline steps to be taken to decrease the recipient's dependence on continuing use of nutritional supplements; (10-1-91)
 - iii. Documentation of evaluation and updating of the nutritional plan and assessment by a physician periodically as determined by the Department. (10-22-93)
- c. Limitations. (10-22-93)
 - i. Incontinent supplies are covered for persons over four (4) years of age only. (10-22-93)
 - ii. Disposable diapers are restricted in number to: Two hundred forty (240) per month for child's briefs; and one hundred eighty (180) per month for adult's briefs. Effective October 1, 1993, if the physician documents that additional briefs are medically necessary, the Department may authorize additional amounts on an individual basis. (12-3-93)
 - iii. Disposable underpads are restricted to one hundred fifty (150) per month. (10-22-93)
- 05. Program Abuse. The use or provision of DME/medical supply items to an individual other than the recipient for which such items were ordered is prohibited. Violators are subject to penalties for program fraud and/or abuse which will be enforced by the Department. The Department shall have no obligation to repair or replace any piece of durable medical equipment that has been damaged, defaced, lost or destroyed as a result of neglect, abuse, or misuse of the equipment. Recipients suspected of the same shall be reported to the SUR/S committee. (10-22-93)
- 06. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, a copy of the authorization letter must be attached to the claim form when submitted. (11-1-86)
- 07. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04 Individual Provider Fees. (12-31-91)

107. OXYGEN AND RELATED EQUIPMENT.

MA will provide payment for oxygen and oxygen-related equipment based upon the Department's fee schedule. Such services are considered reasonable and necessary only with recipients with significant hypoxemia. In addition, providers must be eligible for Medicare program participation prior to the issuance of a Medicaid provider number. (11-1-86)

- 01. Medical Documentation. Oxygen and related equipment are provided only upon the written order of a physician. Once received, such orders will remain in effect for one (1) year and must contain at least the following: (11-1-86)
 - a. A diagnosis of the disease requiring home oxygen use; and (11-1-86)
 - b. The flow rate and oxygen concentration; and (11-1-86)
 - c. An estimate of the frequency and duration of use. A prescription of "oxygen PRN" or "oxygen as

needed" is not acceptable. (11-1-86)

d. Request for home use oxygen must contain the laboratory evidence prescribed in Subsection 107.02. (5-1-92)

i. Age zero (0) to six (6) months of age require physician orders ONLY. (10-22-93)

ii. Age seven (7) months to twenty (20) years of age require letter of authorization from the EPSDT Program Coordinator as being "medically necessary" if lab studies and MD order are not provided which meet program requirements of Subsection 107.02. (7-1-97)

iii. Age twenty-one (21) or older require lab studies and physician orders. No preauthorization is required. (10-22-93)

e. A portable oxygen system may be covered to complement a stationary system if necessary, or by itself, to provide oxygen for use during exercise by a recipient with exercise-induced hypoxemia. To be considered, a request for a portable oxygen system must include: (10-22-93)

i. A description of the activities or exercise routine that a recipient undertakes on a regular basis which requires a portable oxygen system in the home; and (11-1-86)

ii. A description of the medically therapeutic purpose to be served by the portable system that cannot be served by a stationary system; and (11-1-86)

iii. Documentation that the use of the portable system results in clinical improvement in the recipient's condition. (11-1-86)

02. Laboratory Evidence. Initial claims for oxygen therapy must include: (11-1-86)

a. The results of a blood gas study as evidence of the need of administration of oxygen in the home. This may be either a measurement of the partial pressure of oxygen (PO₂) in arterial blood or a measurement of arterial oxygen saturation obtained by oximetry. Because of the potential for conflict of interest, the results of arterial blood gas and/or oxygen saturation tests conducted by the oxygen supplier cannot be used to establish the recipients need for home oxygen. This restriction applies to the suppliers' employee, its corporate officers, or any associated or related organization. The results must come from tests conducted by a provider who will not benefit financially from a finding of coverage for home oxygen services; and (10-22-93)

b. The condition under which the studies are performed must be stated, i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen the amount, body position during testing, and similar information necessary for interpreting the evidence; and (11-1-86)

c. Laboratory evidence of the need for oxygen therapy due to significant hypoxemia will be considered to exist in the following circumstances; (5-1-92)

i. An arterial PO₂ at or below fifty-five (55) mmHg or an arterial oxygen saturation at or below eighty-eight percent (88%), taken at rest, breathing room air; or (7-1-97)

ii. An arterial PO₂ at or below fifty-five (55) mmHg or an arterial oxygen saturation at or below eighty-eight percent (88%) taken during sleep for a patient who demonstrates an arterial PO₂ at or above fifty-six (56) mmHg, or an arterial oxygen saturation at or above eighty-nine percent (89%) while awake or greater than normal fall in oxygen level during sleep (a decrease in arterial PO₂ more than ten (10) mmHg or a decrease in arterial oxygen saturation more than five percent (5%)) associated with symptoms or signs reasonably attributable to hypoxemia, i.e., impairment of cognitive processes and nocturnal restlessness or insomnia. In either of these cases, coverage is provided only for nocturnal use of oxygen; or (7-1-97)

iii. If during exercise it is demonstrated that the oxygen saturation level falls below eighty-eight percent (88%), supplemental oxygen will be provided during exercise if there is evidence that the use of oxygen

improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air. (5-1-92)

d. Coverage is provided for patients whose arterial PO₂ is at or above fifty-six (56) mmHg or whose arterial blood oxygen saturation is at or above eighty-nine percent (89%) if there is: (7-1-97)

i. Dependent edema suggesting congestive heart failure; or (11-1-86)

ii. "P" pulmonale on EKG (P wave greater than three (3) mm in standard leads II, III, or AVF); or (7-1-97)

iii. Erthrocythemia with a hematocrit greater than fifty-six percent (56%). (11-1-86)

03. Service Exclusions. Payment is excluded in the following circumstances: (11-1-86)

a. Recipients with angina pectoris in the absence of hypoxemia; and (11-1-86)

b. Recipients who experience breathlessness without corpulmonale or evidence of hypoxemia; and (11-1-86)

c. Recipients with severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities; and (7-1-97)

d. Recipients with terminal illnesses that do not affect the lungs. (11-1-86)

04. Recipients Currently Receiving Home Oxygen. Below are the recertification requirements for recipients currently receiving home oxygen: (7-1-97)

a. Recertification is required three (3) months after initial certification (i.e., with the fourth month's claim) in patients: (7-1-97)

i. Whose arterial PO₂ was fifty-six (56) mmHg or greater, or whose oxygen saturation was eighty-nine percent (89%) or greater on the initial certification, or (7-1-97)

ii. In whom the physician's initial estimate of length of need for oxygen was one (1) to three (3) months. (7-1-97)

b. For those patients for whom recertification at three (3) months is not required, recertification will be required by twelve (12) months after initial certification (i.e. by the thirteenth month's claim). (7-1-97)

c. Once one (1) certification establishes the medical necessity for continued use of home oxygen, subsequent recertification will not be routinely required. (7-1-97)

d. Initial certification and three (3) month recertification required because of initial PO₂ of fifty-six (56) mmHg or greater or oxygen saturation of eighty-nine percent (89%) or greater must include the results of a recently performed arterial blood gas (ABG) or oximetry test. For other recertification, retesting is not required, but the results of the most recent ABG or oximetry test representing the patient's chronic stable state must be included on the form. (7-1-97)

e. The Department may require subsequent recertification in individual cases. (7-1-97)

05. Cost Considerations. The Department will work with the physician, provider, and recipient to provide payment for the most cost-effective oxygen system that will meet the recipient's medical needs. (11-1-86)

108. AUDIOLOGY SERVICES.

The Department will pay for audiometric services and supplies in accordance with the following guidelines and limitations: (10-1-91)

01. Audiology Examinations. When specifically ordered by a physician, all recipients are eligible for audiometric examination and testing once in each calendar year. Basic audiometric testing by certified audiologists and/or licensed physicians will be covered without prior approval. (10-1-91)

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done. A copy of the physician's order must be attached to the claim for payment. (10-1-91)

03. Hearing Aids. The Department will cover the purchase of one (1) hearing aid per recipient with the following requirements and limitations: (10-1-91)

a. All hearing aid purchases require prior authorization from the Department. (10-22-93)

b. The following information shall be included with the request for preauthorization: the recipient's diagnosis, prognosis, 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, the brand name and model type needed. However, the Department will allow medical doctors to forego the impedance test based on their documented judgement. (7-1-97)

c. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold and/or aid during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (10-22-93)

d. The following services may be covered in addition to the purchase of the hearing aid without prior authorization: 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. (7-1-97)

e. Lost, misplaced, stolen or destroyed hearing aids shall be the responsibility of the recipient. The Department shall have no responsibility for the replacement of any hearing aid. In addition, the Department shall have 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. (7-1-97)

04. Payment Procedures. The following procedures shall be followed when billing the Department: (10-1-91)

a. The Department will only pay the hearing aid provider for an eligible Medicaid recipient if a properly completed claim is submitted to the Department within the one (1) year billing limitation. (10-22-93)

b. Payment will be based upon the Department's fee schedule (See Subsections 060.04 and 060.05). (12-31-91)

05. Limitations. The following limitations shall apply to audiometric services and supplies: (10-1-91)

a. Hearing aid selection is restricted to the type and model which the Bureau has prior approved. (10-22-93)

b. Follow-up services are included in the purchase of the hearing aid for the first two (2) years including, but not limited to, repair, servicing and refitting of ear molds. (7-1-97)

c. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased from them by the Department and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid. (7-1-97)

d. Providers shall not bill recipients for charges in excess of the fees allowed by the Department for materials and services. (7-1-97)

e. Audiology services will be a benefit for EPSDT eligible recipients under the age of twenty-one (21) (See Section 100). (12-31-91)

109. (RESERVED).

110. LABORATORY AND RADIOLOGY SERVICES.

01. Qualifications. Laboratories in a physician's office or a physician's group practice association, except when physicians personally perform their own patients' laboratory tests, must be certified by the Idaho Bureau of Laboratories and be eligible for Medicare certification for participation. All other Idaho laboratories must fulfill these requirements. (2-15-86)

02. Payment Procedures. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of an independent laboratory that can bill for a reference laboratory. A physician is not an independent laboratory. (2-15-86)

a. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (2-15-86)

b. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (2-15-86)

c. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule as described in Section 085. The payment level for other laboratory tests will be at a rate established by the Department. (12-31-91)

d. Collection fees for specimens drawn by veinpuncture or catheterization are payable only to the physician or laboratory who draws the specimen. (2-15-86)

111. (RESERVED).

112. REHABILITATIVE SERVICES - - MENTAL HEALTH.

Pursuant to 42 CFR 440.130(d), the Department shall purchase rehabilitative services for maximum reduction of mental disability and restoration of the recipient to the best possible functional level. Services shall be provided through the State Mental Health Authority in each region, hereafter referred to as the Community Support Program (CSP), in accordance with Title 39, Chapter 31, Idaho Code, Regional Mental Health Services. Each region shall deliver a range of Community Support Program (CSP) services in their communities including treatment, rehabilitation and supportive services. (7-1-94)

01. Responsibilities of Regions. Each region shall enter into a provider agreement with the Division of Medicaid for CSP services and shall be responsible for the following: (7-1-94)

a. Develop, maintain and coordinate a region-wide, comprehensive and integrated service system of department and other providers. (7-1-94)

b. Provide CSP services directly, or through contracts with other providers. (7-1-94)

c. Assure provision of CSP services to recipients on a twenty-four (24) hour basis. (7-1-94)

d. Assure completion of an intake assessment and service plan for each recipient. (7-1-94)

e. Provide service authorizations and functions required to administer this section. (7-1-94)

f. Monitor the quality of services provided in this section in coordination with the Divisions of

Welfare and Family and Community Services. (7-1-94)

02. Service Descriptions. A CSP shall consist of the following services: (7-1-94)

a. A comprehensive assessment shall be completed for each recipient of CSP services which addresses the recipient's assets, deficits and needs directed towards formulation of a written diagnosis and treatment plan. Assessment is an interactive process with the maximum feasible involvement of the recipient. The assessment, with supplemental psychiatric, psychological, or specialty evaluations and tests, must be in written form, dated and signed. They must be retained in the recipient's file for documentation purposes. Should the assessment reveal that the person does not need rehabilitative services, appropriate referrals shall be made to meet other needs of the recipient. The assessment is reimbursable if conducted by a qualified provider, in accordance with Subsections 112.04.a. through 112.04.f. All the following areas must be evaluated and addressed: (7-1-94)

i. Psychiatric history and current mental status which includes at a minimum, age at onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the recipient manifests, the recipient's ability to identify his symptoms, medication history, substance abuse history, history of mental illness in the family, current mental status observation, any other information that contributes to the recipient's current psychiatric status; and (7-1-94)

ii. Medical history and current medical status which includes at a minimum, history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications, name of current physician; and (7-1-94)

iii. Vocational/Educational status which includes at a minimum, current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment; and (7-1-94)

iv. Financial status which includes at a minimum, adequacy and stability of the recipient's financial status, difficulties the recipient perceives with it, resources available, recipient's ability to manage personal finances; and (7-1-94)

v. Social relationships/support which includes, at a minimum, recipient's ability to establish/maintain personal support systems or relationships and recipient's ability to acquire leisure, recreational, or social interests; and (7-1-94)

vi. Family status which includes, at a minimum, the recipient's ability or desire to carry out family roles, recipient's perception of the support he receives from his family, and the role the family plays in the recipient's mental illness; and (7-1-94)

vii. Basic living skills which includes at a minimum, recipient's ability to meet basic living needs, what the recipient wants to accomplish in this area; and (7-1-94)

viii. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, present situation as appropriate to the recipient's needs; and (7-1-94)

ix. Community/Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the recipient has in the community, daily living skills necessary for community living. (7-1-94)

b. A written service plan shall be developed and implemented for each recipient of CSP services as a vehicle to address the rehabilitative needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family and other support systems. The written service plan shall be developed within thirty (30) calendar days from the date the recipient chooses the agency as his provider. Case planning is reimbursable if conducted by a qualified provider, in accordance with Subsections 112.04.a. through 112.04.f. The case plan must include, at a minimum: (7-1-94)

i. A list of focus problems identified during the assessment; and (7-1-94)

- ii. Concrete, measurable goals to be achieved, including time frames for achievement; and (7-1-94)
- iii. Specific objectives directed toward the achievement of each one of the goals; and (7-1-94)
- iv. Documentation of participants in the service planning; the recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient; and (7-1-94)
- v. Reference to any formal services arranged, including specific providers where applicable; and (7-1-94)
- vi. Planned frequency of services initiated. (7-1-94)
- c. Individual, group and family psychotherapy shall be provided in accordance with the objectives specified in the written service plan. (7-1-94)
 - i. These services are reimbursable if provided by a qualified professional, including a psychiatrist, physician, registered nurse, psychologist, clinician, or social worker in accordance with Subsections 112.04.a. through 112.04.e. (7-1-94)
 - ii. Family psychotherapy must include the recipient and at least one (1) family member at any given time and must be delivered in accordance with objectives as specified in the written service plan. (7-1-94)
- d. Pharmacologic management services shall be provided in accordance with the service plan. (7-1-94)
 - i. Medication prescription must be done by a licensed physician or licensed nurse practitioner in direct contact with the recipient. (7-1-94)
 - ii. Licensed and qualified nursing personnel can supervise, monitor, or administer medications within the limits of the Nurse Practice Act, Section 54-1402 (d), Idaho Code. (7-1-94)
 - iii. Other CSP providers, included in Subsection 112.04, may assist in "self" administration by verbal prompts. (7-1-94)
- e. Individual Psychosocial Rehabilitation shall be provided in accordance with the objectives specified in the service plan. The service plan goal is to aid recipients in work, school or other problems related to their mental illness, in obtaining skills to live independently or in preventing movement to a more restrictive living situation. Individual psychosocial rehabilitation is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with Subsection 112.04. This service includes one (1) or more of the following: (7-1-94)
 - i. Assistance in gaining and utilizing skills necessary to undertake school or employment. This includes helping the recipient learn personal hygiene and grooming, securing appropriate clothing, time management and other skills related to recipient's psychosocial condition. (7-1-94)
 - ii. Ongoing, on-site assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer or teacher. (7-1-94)
 - iii. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior. (7-1-94)
 - iv. Problem solving, support, and supervision related to activities of daily living to assist recipients to gain and utilize skills including, but not limited to, personal hygiene, household tasks, transportation utilization, and money management. (7-1-94)

v. To assist the acquisition of necessary services when recipients are unable to obtain them by escorting them to Medicaid reimbursable appointments. (7-1-94)

vi. Medication education may be provided by a licensed physician or licensed nurse focusing on educating the recipient about the role and effects of medications in treating symptoms of mental illness. (2-6-95)

f. Group psychosocial rehabilitation shall be provided in accordance with the objectives specified in the service plan. This is a service to two or more individuals, at least one of whom is a recipient. The service plan goal is to aid recipients in work, school or other problems related to their mental illness, in obtaining skills to live independently or in preventing movement to a more restrictive living situation. Group psychosocial rehabilitation is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with Subsection 112.04. This service includes one (1) or more of the following: (7-1-94)

i. Medication education groups provided by a licensed physician or licensed nurse focusing on educating recipients about the role and effects of medications in treating symptoms of mental illness. These groups must not be used solely for the purpose of group prescription writing. (7-1-94)

ii. Employment or school related groups to focus on symptom management on the job or in school, anxiety reduction, and education about appropriate job or school related behaviors. (7-1-94)

iii. Groups in communication and interpersonal skills, the goals of which are to improve communication skill and facilitate appropriate interpersonal behavior. (7-1-94)

iv. Symptom management groups to identify symptoms of mental illnesses which are barriers to successful community integration, crisis prevention, identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons. (7-1-94)

v. Groups on activities of daily living which help recipients learn skills related to, but not limited to, personal hygiene and grooming, household tasks, transportation utilization and money management. (7-1-94)

g. Community crisis support which includes intervention for recipients in crisis situations to ensure the health and safety or to prevent hospitalization or incarceration of a recipient. (7-1-94)

i. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. (7-1-94)

ii. Community crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service, even if it is not in the service plan. (7-1-94)

iii. Community crisis support is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with Subsection 112.04. (7-1-94)

03. Excluded Services. (7-1-94)

a. Treatment services rendered to recipients residing in inpatient medical facilities including nursing homes or hospitals. (7-1-94)

b. Recreational therapy which includes activities which are primarily social or recreational in nature. (7-1-94)

c. Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job training or coaching. (7-1-94)

d. Staff performance of household tasks and chores. (7-1-94)

- e. Targeted Case Management as provided under the state plan. (7-1-94)
- f. Any other services not listed in Subsection 112.02. (7-1-94)
- 04. Community Support Program Provider Staff Qualifications. All individual providers must be employees of the State Mental Health Authority in each region or employees of an agency contracting with the Department to provide Community Support services. The employing entity shall supervise individual CSP providers and assure that the following qualifications are met for each individual provider: (7-1-94)
 - a. A physician shall be licensed in accordance with Title 54, Chapter 18, Idaho Code to practice medicine; (7-1-94)
 - b. A nurse shall be licensed in accordance with Title 54, Chapter 14, Idaho Code; (7-1-94)
 - c. A psychologist shall be licensed in accordance with Title 54, Chapter 23, Idaho Code; (7-1-94)
 - d. A clinician shall be employed by a state agency and meet the minimum standards established by the Idaho Personnel Commission. (7-1-94)
 - e. A social worker shall hold a license in accordance with Title 54, Chapter 32, Idaho Code; (7-1-94)
 - f. A psychosocial rehabilitation specialist shall hold a bachelor's degree in a behavioral science such as social work, psychology, marriage and family counseling, psychosocial rehabilitation, or a closely related field; (7-1-94)
 - g. An occupational therapist shall be licensed in accordance with Chapter 54, Idaho Code. (7-1-94)
- 05. Record Requirements. In addition to the development and maintenance of the treatment plan, the following documentation must be maintained by the provider: (7-1-94)
 - a. Name of recipient; and (7-1-94)
 - b. Name of the provider agency and person providing the service; and (7-1-94)
 - c. Date, time, and duration of service; and (7-1-94)
 - d. Activity record describing the recipient and the service provided; and (7-1-94)
 - e. Documented review of progress toward each service plan goal and assessment of recipient's need for services at least every one hundred twenty (120) days. (2-6-95)
- 06. Payment for Services. Payment for CSP services must be in accordance with rates established by the Department. (7-1-94)
 - a. Payment for services shall not duplicate payment made to public or private entities under other program authorities for the same purpose. (7-1-94)
 - b. Only one (1) staff member may bill for an assessment, treatment plan, or case review when multiple CSP staff are present. (7-1-94)
 - c. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Idaho Code. CSP staff shall not be paid for other medical procedures. For example, changing dressings on a wound. (7-1-94)
 - d. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules shall be cause for recoupment of payments for services, sanctions, or both. (7-1-94)

e. The provider shall provide the Department with access to all information required to review compliance with these rules. (7-1-94)

f. Psychiatric or psychological evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (7-1-94)

g. Psychological evaluations are reimbursable if provided by a qualified clinician, in accordance with Subsection 112.04.d., under the direction of a psychologist, Ph.D. (7-1-94)

h. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with development of a service plan are reimbursable. (7-1-94)

07. Service Limitations. The following service limitations shall apply to CSP services, unless otherwise authorized by the State Mental Health Authority in each region. (7-1-94)

a. A combination of any evaluation or diagnostic services are limited to a maximum of six (6) hours annually. (7-1-94)

b. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (7-1-94)

c. Community crisis support services are limited to a maximum of four (4) hours per day during a period of five (5) consecutive days and must receive prior authorization from the State Mental Health Authority in each region. (7-1-94)

d. Individual and group psychosocial rehabilitation services are limited to twenty (20) hours per week and must receive prior authorization from the State Mental Health Authority in each region. Services in excess of twenty (20) hours require additional review and prior authorization by the State Mental Health Authority in each region. (7-1-94)

113. (RESERVED).

114. CLINIC SERVICES - DIAGNOSTIC SCREENING CLINICS.

The Department will reimburse medical social service visits to clinics which coordinate the treatment between physicians and other medical professionals for recipients which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (4-1-91)

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each recipient and responsible parent or guardian. Diagnostic and consultative services related to the diagnosis and treatment of the recipient will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. (4-1-91)

02. Billings. No more than five (5) hours of medical social services per recipient may be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges recipient treatments and provides medical information to providers which have agreed to coordinate the care of their patient. (4-1-91)

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. (12-31-91)

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. (4-1-91)

05. Services Reimbursed. Services performed by a diagnostic and screening clinic will be reimbursed under a fee for service basis as established by Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, Section 406, "Rules Governing Medicaid Provider Reimbursement in Idaho." (12-31-91)

115. CLINIC SERVICES -- MENTAL HEALTH CLINICS.

Pursuant to 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 recipient who is not an inpatient in a hospital or nursing home except as specified under Subsection 115.05.d. The mental health clinic must be approved by the Department and be under the direction of a licensed physician. (12-31-91)

01. Care and Services Provided. (12-31-91)
 - a. Services must be provided specifically in conjunction with a medically ordered plan of care when delivered by licensed, qualified professionals employed full or part-time within a clinic. (11-10-81)
 - b. All treatment must be based on an individualized assessment of the patient's needs, and provided under the direct supervision of a licensed physician. (11-10-81)
 - c. All medical care plans must: (11-10-81)
 - i. Be dated and fully signed with title identification by both the prime therapist(s) and licensed physician; and (11-10-81)
 - ii. Contain the diagnosis, problem list, type, frequency, and duration of treatment; and (11-10-81)
 - iii. Be reviewed and authorized and signed within thirty (30) days of implementation; and (11-10-81)
 - iv. Be reviewed within one hundred twenty (120) days and every one hundred twenty (120) days thereafter; and (11-10-81)
 - v. Be completely rewritten and authorized annually. (11-10-81)
 - d. Licensed, qualified professionals providing clinic services to eligible MA recipients must have, at a minimum, one (1) or more of the following degrees: (11-10-81)
 - i. Psychiatrist, M.D.; or (11-10-81)
 - ii. Physician, M.D.; or (11-10-81)
 - iii. Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)
 - iv. Licensed Certified Social Workers, Licensed Social Workers; or (11-10-81)
 - v. Psychiatric Nurse, R.N.; or (11-10-81)
 - vi. Mental Health Rehabilitation Specialist, Registered Occupational Therapist, O.T.R. (11-10-81)
02. Care and Services not Covered. (11-10-81)
 - a. The MA Program will not pay for clinic services rendered to MA recipients residing in in-patient medical facilities including, but not limited to, nursing homes or hospitals; or (11-10-81)
 - b. Any service or supplies not included as part of the allowable scope of the MA Program; or (11-10-81)
 - c. Services provided within the clinic framework by persons other than those qualified to render services as specified in Section 115. (12-31-91)
03. Evaluation and Diagnostic Services. (11-10-81)
 - a. Medical psychosocial intake histories must be contained in all case files. (11-10-81)

- b. Information gathered will be used for establishing a recipient data base used in part to formulate the diagnosis and treatment plan. (11-10-81)
- c. The medical psychosocial intake is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following degrees: (11-10-81)
 - i. Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)
 - ii. Licensed Certified Social Worker or Licensed Social Worker; or (11-10-81)
 - iii. Psychiatric Nurse, R.N.; or (11-10-81)
 - iv. Licensed Physician, M.D. (11-10-81)
- d. If an individual who is not eligible for MA receives intake services from any staff not having the required degree(s) as provided in Subsection 115.03.c., and later becomes eligible for MA, a new intake assessment and treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. (12-31-91)
- e. Any provider of evaluation, diagnostic service, or treatment designed by any person other than a person designated as qualified by these rules, is not eligible for reimbursement under the MA Program. (11-10-81)
- f. Psychiatric or psychological testing may be provided in conjunction with the medical psychosocial intake history as a reimbursable service. (11-10-81)
- g. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of a medical care treatment plan are reimbursable. (11-10-81)
- h. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the recipient's file for documentation purposes. (11-10-81)
- i. All data gathered must be directed towards formulation of a written diagnosis, problem list, and treatment plan which specifies the type, frequency, and anticipated duration of treatment. (11-10-81)
- j. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services provided to an eligible recipient in a calendar year. A calendar year begins on the first date of service provided to an eligible recipient. (11-10-81)
- 04. Treatment Services. (11-10-81)
 - a. Individual and group psychotherapy must be provided in accordance with the goals specified in the written medical treatment plan. (11-10-81)
 - b. Family-centered psychosocial services must include at least two (2) family members and must be delivered in accordance with the goals of treatment as specified in the medical treatment plan. (11-10-81)
 - c. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (11-10-81)
 - i. Emergency services provided to an eligible recipient prior to intake and evaluation is a reimbursable service but must be fully documented in the recipient's record; and (11-10-81)
 - ii. Each emergency service will be counted as a unit of service and part of the allowable limit per recipient unless the contact results in hospitalization. (11-10-81)

- d. Psychotherapy services may be provided to recipients residing in a nursing facility if the following criteria are met: (11-29-91)
- i. The recipient has been identified through the PASARR Level II screening process as requiring psychotherapy as a specialized service; and (11-29-91)
- ii. The service is provided outside the nursing facility at a clinic location or other location where clinic staff is available; and (11-29-91)
- iii. Services provided are: (11-29-91)
- (1) Supported by the independent evaluations completed and approved by the Mental Health Authority; and (11-29-91)
- (2) Incorporated into the recipient's medical care plan; and (11-29-91)
- (3) Directed toward the achievement of specific measurable objectives which include target dates for completion. (11-29-91)
- e. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 115.04.a. through 115.04.d. must have, at a minimum, one (1) or more of the following degrees: (11-29-91)
- i. Psychiatrist, M.D.; or (11-29-91)
- ii. Physician, M.D.; or (11-10-81)
- iii. Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)
- iv. Licensed Certified Social Workers, Licensed Social Workers; or (11-10-81)
- v. Psychiatric Nurse, R.N. (11-10-81)
- f. Psychotherapy services as set forth in Subsections 115.04.a. through 115.04.c. are limited to forty-five (45) hours per calendar year. (12-31-91)
- g. Chemotherapy consultations must be provided by a physician or licensed nurse practitioner in direct contact with the recipient. (11-10-81)
- i. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the treatment plan; and (11-10-81)
- ii. Chemotherapy treatment can be part of the medical care plan and frequency and duration of the treatment must be specified. (11-10-81)
- h. Nursing services, when physician ordered and supervised, can be part of the recipient's medical care plan. (11-10-81)
- i. Licensed and qualified nursing personnel can supervise, monitor, and/or administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (11-10-81)
- ii. Such treatment can be part of the recipient's medical care plan and frequency and duration of the treatment must be specified. (11-10-81)
- i. Partial care services will be directed toward the maintenance of socio-emotional levels, reduction of psychosocial dysfunctioning, and the promotion of psychosocial levels of functioning. (11-10-81)
- i. To qualify as a partial care service, the service must be offered a minimum of three (3) continuous

- hours daily, four (4) days per week; and (11-10-81)
- ii. Treatment will be limited to fifty-six (56) hours per week per eligible recipient; and (7-8-90)
 - iii. Partial care services offered on an extension basis less than this standard are allowable when such services are directly affiliated with a partial care service that meets this standard; and (11-10-81)
 - iv. Partial care services will be part of the recipient's medical care plan which must specify the amount, frequency, and expected duration of treatment; and (11-10-81)
 - v. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the following degrees: (11-10-81)
 - (1) Psychiatrist, M.D.; or (11-10-81)
 - (2) Physician, M.D.; or (11-10-81)
 - (3) Psychologist, Ph.D., Ed.D., M.A./M.S.; or (11-10-81)
 - (4) Licensed Certified Social Worker, Licensed Social Worker; or (11-10-81)
 - (5) Registered Nurse, R.N.; or (11-10-81)
 - (6) Registered Occupational Therapist. (11-10-81)
05. Record Keeping Requirements. (11-10-81)
- a. Each clinic will be required to maintain records on all services provided to MA recipients. (11-10-81)
 - b. The records must contain a current treatment plan ordered by a physician and must meet the requirements as set forth in Subsection 115.01.c. (12-31-91)
 - c. The records must: (11-10-81)
 - i. Specify the exact type of treatment provided; and (11-10-81)
 - ii. Who the treatment was provided by; and (11-10-81)
 - iii. Specify the duration of the treatment; and (11-10-81)
 - iv. Contain detailed records which outline exactly what occurred during the therapy session or recipient contact; and (11-10-81)
 - v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (11-10-81)
 - d. Any service not adequately documented in the recipient's record by the signature of the therapist providing the therapy or recipient contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (11-10-81)
 - e. Any treatment or contact provided as a result of a treatment plan performed by any staff other than as set forth herein will not be eligible for reimbursement by the Department. (11-10-81)
 - f. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the recipient are subject to recoupment. (11-10-81)

06. Payment Procedures. (11-10-81)

a. Payment for clinic services will be made directly to the clinic and will be in accordance with rates established by the Department for the specific services. (11-10-81)

b. Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the MA recipient for any portion of any charges incurred for the cost of his care. (11-10-81)

c. All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payors will be required by the Department. (11-10-81)

d. Payment for the administration of injections must be in accordance with rates established by the Department. (11-10-81)

116. TARGETED CASE MANAGEMENT FOR THE MENTALLY ILL.

The Department will purchase case management (CM) services for adult Medicaid recipients with severe disabling mental illness. Services will be provided by an organized provider agency which has entered into a provider agreement with the Department. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services. (8-1-92)

01. Eligible Target Group. Only those individuals who are mentally ill and eighteen (18) years of age or older who are at risk of using high cost medical services associated with frequent exacerbations of mental illness are eligible for CM services. (8-1-92)

a. The following diagnostic and functional criteria will be applied to determine membership in this target population: (8-1-92)

i. Diagnosis: A condition of severe and persistent mental illness and a diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) within one (1) of the following classification codes for: (8-1-92)

(1) Schizophrenia - 295.1,.2,.3,.6 and.9; (8-1-92)

(2) Organic mental disorders associated with Axis III physical disorders or conditions, or whose etiology is unknown - 293.00, 293.81, 293.82, 293.83, 294.00, 294.10, 294.80, 310.10; (8-1-92)

(3) Affective disorders - 296.2, 296.3, 296.4, 296.5, 296.6, 296.7, 300.4, 301.13, 311.0; (8-1-92)

(4) Delusional disorder - 297.1; (8-1-92)

(5) Other psychotic disorders - 295.4, 295.7, 297.3, 298.8 and 298.9; (8-1-92)

(6) Personality disorders - 301.00, 301.22, 301.83. (8-1-92)

(7) If the only diagnosis is one (1) or more of the following, the person is not included in the target population for CM services: (8-1-92)

(a) Mental retardation; or (8-1-92)

(b) Alcoholism; or (8-1-92)

(c) Drug abuse. (8-1-92)

ii. Functional limitations: The psychiatric disorder must be of sufficient severity to cause a disturbance in the role performance or coping skills in at least two (2) of the following areas, on either a continuous

(more than once per year) or an intermittent (at least once per year) basis: (8-1-92)

(1) Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history. (8-1-92)

(2) Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support him or manage his finances without assistance. (8-1-92)

(3) Social/interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (8-1-92)

(4) Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family. (8-1-92)

(5) Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (8-1-92)

(6) Housing: Has lost or is at risk of losing his current residence. (8-1-92)

(7) Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior which results in intervention by law enforcement and/or the judicial system. (8-1-92)

(8) Health: Requires assistance in maintaining physical health or in adhering to medically prescribed treatment regimens. (8-1-92)

b. Recipients may reside in adult foster care, residential care, semi-independent living, room and board or their own homes. (8-1-92)

c. Recipients may be receiving homemaker, personal care, home health, respite or other services. (8-1-92)

d. Recipients who elect hospice services as found in Section 104, or are receiving case management services through another program are excluded from CM services. (8-1-92)

02. Services Descriptions. CM services shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational and social services in the least restrictive, most appropriate and most cost-effective setting. CM services shall consist of the following core functions: (8-1-92)

a. Assessment: A CM provider must have the capacity to perform written comprehensive assessments of a person's assets, deficits and needs. Assessment is an interactive process with the maximum feasible involvement of the recipient. Should the assessments reveal that the person does not need CM services, appropriate referrals will be made to meet other needs of the participant. All the following areas must be evaluated and addressed: (8-1-92)

i. Psychiatric history and current mental status: Includes but is not limited to age of onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the client manifests, is the client able to identify his symptoms, medication history; substance abuse history, history of mental illness in the family, current mental status observation, any other information that contributes to their current psychiatric status; and (10-22-93)

ii. Medical history and current medical status: Includes but is not limited to history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications; name of current physician; and (10-22-93)

iii. Vocational status: Includes but is not limited to current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment; and (10-22-93)

iv. Financial status: Includes but is not limited to adequacy and stability of the client's financial status, what difficulties they perceive with it, what resources may be available, client's ability to manage personal finances; and (10-22-93)

v. Social relationships/support: Includes but is not limited to client's ability to establish/maintain personal support systems or relationships, client's ability to acquire leisure, recreational, or social interests; and (10-22-93)

vi. Family status: Includes but is not limited to: client's ability or desire to carry out family roles, client's perception of the support he receives from their family, what role does the family play in the client's mental illness; and (10-22-93)

vii. Basic living skills: Includes but is not limited to client's ability to meet their basic living needs, what does the client want to accomplish in this area; and (10-22-93)

viii. Housing: Includes but is not limited to: current living situation and level of satisfaction with the arrangement, is present situation appropriate to the client's needs; and (8-1-92)

ix. Community/Legal status: Includes but is not limited to legal history with law enforcement, transportation needs, supports the client has in the community, daily living skills necessary for community living. (8-1-92)

b. Service Plan Development and Implementation. Following the assessment(s) and determination of need for CM, a written service plan shall be developed and implemented as a vehicle to address the case management needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support system, and the CM provider. The written service plan shall be developed within thirty (30) calendar days of when the recipient chooses the agency as his provider and must include, at a minimum: (8-1-92)

i. A list of focus problems identified during the assessments; and (8-1-92)

ii. Concrete, measurable goals to be achieved, including time frames for achievement; and (8-1-92)

iii. Specific plans directed toward the achievement of each one of the goals; and (8-1-92)

iv. Documentation of who has been involved in the service planning; the recipient, if possible, must be involved. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided as to why this was not possible. A copy of the plan must be given to the recipient; and (8-1-92)

v. Reference to any formal services arranged, including specific providers where applicable; and (8-1-92)

vi. Planned frequency of services initiated. (8-1-92)

c. Crisis Assistance. Crisis assistance services are those case management activities that are needed in addition to the assessment and ongoing case management hours in emergency situations. These are necessary activities to obtain services needed to ensure the health and/or safety or to prevent hospitalization or incarceration of a recipient. Crisis assistance may be provided prior to or after the completion of the assessments and individual service plan. (8-1-92)

d. Linking/Coordination of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as: assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need

for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face-to-face contact with the recipient at least every thirty (30) days.
(10-22-93)

e. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation and Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system.
(10-22-93)

03. CM Provider Agency Qualifications. Case management provider agencies must meet the following criteria:
(8-1-92)

a. Utilization of a standardized intake and prescreening process for determining whether or not Medicaid eligible individuals are included in the target group for case management services. Prescreening must be effective in sorting out who does and who does not need a full assessment of needs for CM.
(8-1-92)

b. Demonstrated capacity in providing all core elements of case management services to the target population including:
(8-1-92)

i. Comprehensive assessment; and
(8-1-92)

ii. Comprehensive service plan development and implementation; and
(8-1-92)

iii. Crisis assistance; and
(8-1-92)

iv. Linking/coordination of services; and
(8-1-92)

v. Encouragement of independence.
(10-22-93)

c. Provides clients of the agency, the availability of a case manager on a twenty-four (24) hour basis to assist them in obtaining needed services.
(8-1-92)

04. CM Provider Staff Qualifications. All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual CM providers and assure that the following qualifications are met for each individual CM provider:
(8-1-92)

a. Must be a psychiatrist, M.D., D.O.; or physician, M.D., D.O.; or psychologist, Ph.D., Ed.D., M.A./M.S.; or social worker with a valid Idaho social work license issued by the Board of Social Work Examiners; or nurse, R.N.; or have a B.A./B.S. in a human services field and at least one (1) year experience in the psychiatric or mental health field.
(8-1-92)

b. A total caseload per case manager of no more than twenty (20) individuals. The Bureau may grant a waiver of the caseload limit when requested by the agency. The following criteria must be met to justify a waiver:
(8-1-92)

i. The availability of case management providers is not sufficient to meet the needs of the service area.
(8-1-92)

ii. The recipient that has chosen the particular agency or individual case manager that has reached their limit, has just cause to need that particular agency or manager over other available agencies/managers.
(8-1-92)

iii. The request for waiver must include:
(8-1-92)

(1) The time period for which the waiver is requested;
(8-1-92)

- (2) The alternative caseload limit requested; (8-1-92)
- (3) Assurances that the granting of the waiver would not diminish the effectiveness of the CM agency, violate the purposes of the program, or adversely affect the recipients' health and welfare. (8-1-92)
- iv. The Bureau may impose any conditions on the granting of the waiver which it deems necessary. (8-1-92)
- v. The Bureau may limit the duration of a waiver. (8-1-92)
- 05. Recipient's Choice. The eligible recipient will be allowed to choose whether or not he desires to receive CM services. All recipients who choose to receive CM services will have free choice of CM providers as well as the providers of medical and other services under the Medicaid program. (8-1-92)
- 06. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (Subsection 116.02) provided to members of the eligible target group by qualified staff. (8-1-92)
 - a. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (8-1-92)
 - b. Payment will not be made for CM services provided to individuals who are inpatients in nursing homes or hospitals. (8-1-92)
 - c. Reimbursement for the initial evaluation and individual service plan development shall be paid based on an hourly rate, not to exceed eight (8) hours. The rate will be established by the Bureau. (8-1-92)
 - d. Reimbursement for on-going case management services shall be made on an hourly rate for service delivered. The rate will be established by the Bureau. (8-1-92)
 - e. Medicaid reimbursement shall be provided only for the following case management services: (8-1-92)
 - i. Face-to-face contact between the case manager and the recipient; (8-1-92)
 - ii. Telephone contact between the case manager and the recipient, the recipient's mental health and other service providers, a recipient's family members, primary caregivers, legal representative, or other interested persons; (8-1-92)
 - iii. Face-to-face contacts between the case manager and the recipient's family members, legal representative, primary caregivers, mental health providers or other service providers, or other interested persons; (8-1-92)
 - iv. Development, review, and revision of the recipient's individual service plan, including the case manager's functional assessment of the recipient. (8-1-92)
 - f. The Department will not provide Medicaid reimbursement for on-going case management services delivered prior to the completion of the assessments and individual service plan. (8-1-92)
 - g. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and individual service plan. (8-1-92)
 - h. Audit reviews will be conducted at least once a calendar year by the Bureau. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (7-1-94)

i. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (10-22-93)

j. The provider will provide the Department with access to all information required to review compliance with these rules. (10-22-93)

k. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (8-1-92)

l. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. (8-1-92)

i. 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 included in the responsibilities of the facility. (7-1-94)

07. Record Requirements. In addition to the development and maintenance of the service plan, the following documentation must be maintained by the provider: (8-1-92)

a. Name of recipient; and (8-1-92)

b. Name of the provider agency and person providing the service; and (8-1-92)

c. Date, time, and duration of service; and (8-1-92)

d. Place of service; and (8-1-92)

e. Activity record describing the recipient and the service provided; and (8-1-92)

f. Documented review of progress toward each CM service plan goal, and assessment of the recipient's need for CM and other services at least every one hundred twenty (120) days; and (8-1-92)

g. Documentation justifying the provision of crisis assistance to the recipient; and (8-1-92)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management. (8-1-92)

117. CLOZAPINE CARE COORDINATION.

01. Qualifications. The Department will make payments for care coordination services associated with prescribed Clozapine therapy to entities operating manufacturer registered Clozapine treatment systems. (2-19-92)

02. Payment Procedures. A single payment for each calendar week (or portion thereof) will be made. Payments for care coordination services are made in lieu of payments for chemotherapy visits to mental health centers and/or physician medical management services unless significant identifiable services in excess of those required by the manufacturers registered treatment system are required and documented. The rate of payment will be established in accordance with Subsection 060.04. (2-19-92)

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.

The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for adult Medicaid eligible recipients with developmental disabilities when authorized by the Regional ACCESS Unit and provided by an organized service coordination provider agency who has entered into a written provider agreement/contract with the Department. The Department will only provide Targeted Service Coordination in a geographic area where such service is not available through a private provider who has entered into a provider agreement/contract with the Department. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. (3-16-95)

01. Eligible Target Group. Only Medicaid eligible adults, twenty-one (21) years of age or older and eligible individuals between the ages of eighteen (18) and twenty-one (21) who have transition plans developed by the school system which identify service coordination as necessary; and desire to live, learn, or work in community based settings are eligible. All participants must have a primary diagnosis of Developmental Disability. (10-1-94)

a. The following diagnostic and functional criteria will be applied to determine membership in the target population: (1-7-94)

i. "Developmental Disability" means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (10-1-94)

(1) Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition 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 (10-1-94)

(2) 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 (10-1-94)

(3) 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 or coordinated. (10-1-94)

b. Eligible individuals may reside in adult foster care, residential care, semi-independent living, room and board, their own homes, or be homeless. (1-7-94)

c. Eligible individuals may be receiving habilitation, supportive assistance, respite, or other services. (1-7-94)

02. Service Description. TSC shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational, residential, and social services using the least restrictive and most appropriate procedures and settings. TSC shall consist of the following core functions: (10-1-94)

a. Individual Assessment and Service Planning. Unless specifically excluded by the recipient, an Individual Support Plan (ISP) shall be developed in conjunction with the recipient, service providers, the recipient's family and/or guardian and other individuals selected by the recipient. (3-16-95)

i. The ISP shall replace existing service plans, except when such plans are required by other rules, and be developed from a person centered planning process and include information obtained from evaluations (assessments), consumer interview, observation in community settings, and other pertinent information. (10-1-94)

ii. The plan shall be directed at meeting the individual recipient's needs, primarily by building on, maintaining, and utilizing the recipient's identified strengths and abilities. Services proposed must: be the result of on-going planning; be built around the recipient's wants and needs; encourage the recipient to choose the locality in which he lives and works; be age appropriate; include, whenever possible, two (2) or more options from which the recipient may choose; be aimed at maximizing community participation; be culturally appropriate; be designed to promote and utilize natural and informal community supports, including family, friends, and other non-paid citizens; and be designed with supports and services necessary to succeed in his chosen environment. (1-7-94)

iii. The plan must be completed within ninety (90) days of the selection of the service coordinator, unless documentation of a delay based on consumer need is submitted to the regional ACCESS unit. (5-24-95)

iv. The plan must be written in language that is easily understood by the consumer and his team. (5-24-95)

b. The service coordinator is responsible for writing the plan, and submitting it to the Regional

ACCESS Unit for authorization of Medicaid and state general fund eligibility. The service coordinator will be responsible for finding alternative funding/resources for services and supports not deemed eligible for Medicaid or state general fund reimbursement. (10-1-94)

- c. Implementation. The service coordinator shall arrange for services necessary to execute the ISP. (10-1-94)
- d. Monitoring. The service coordinator shall review, update and monitor the plan continuously to meet the recipient's changing needs. (10-1-94)
- i. Discuss the status of the ISP with the recipient in at least one face-to-face contact per month. (10-1-94)
- ii. Discuss all proposed changes and the options related to those changes with the recipient. (1-7-94)
- iii. Maintain regular contact with all service providers active with the recipient, and participate in meetings to facilitate the coordination of services. (1-7-94)
- iv. Discuss the recipient's (family or guardian if appropriate) satisfaction with the quantity and quality of services provided; (1-7-94)
- v. Maintain documentation in the ISP of the service coordinator's (family member or guardian if appropriate) observations of the recipient engaged in ISP objective-oriented behavior; (10-1-94)
- vi. Evaluate progress toward outcomes identified on the ISP. (10-1-94)
- vii. Modify, change, terminate or add services based on these evaluations. (1-7-94)
- e. Enablement. The service coordinator shall enable the recipient whenever possible. Enablement includes but is not limited to the following: (10-1-94)
 - i. Providing information in ways that empower the recipient to make an informed decision; (1-7-94)
 - ii. Assuring that all placements in the service delivery system shall be to services which offer the individual the best available opportunity for personal development, provide an improved quality of life, and are within the least restrictive environment appropriate to the individual. (1-7-94)
 - iii. Ensure that all residential arrangements are community-based. Such arrangements may include, but are not limited to, the recipient's family's residence, or an independent living arrangement. (1-7-94)
 - iv. Ensure that providers comply with clients' rights as specified in the Developmental Disabilities Act. (10-1-94)
 - v. Assure that no one shall be denied TSC on the basis of the severity of physical or mental disability. (10-1-94)
 - vi. If the placement or services which are recommended are not immediately available, continued attempts to try to access the service or placement for the recipient must be documented. (1-7-94)
 - vii. The service coordinator will foster the independence of the recipient (family or guardian if appropriate) by demonstrating to the individual how best to access service delivery systems. (10-1-94)
- 03. Targeted Service Coordination Agency Qualifications. Targeted Service Coordination agencies must meet the following criteria: (10-1-94)
 - a. Demonstrated ability to provide all the core elements listed in Subsection 119.02 of TSC to the target population; and (10-1-94)

b. Provide consumers of the agency, the availability of a care coordinator on a twenty-four (24) hour basis to assist them in obtaining needed services. (10-1-94)

c. May contract with individual service coordinators or case management agencies to provide TSC services. (10-1-94)

d. Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency or their employees/contractors in any other agency that provides services to people with developmental disabilities. (10-1-94)

e. The individual or agency employees successfully complete the service coordination certification training specified by the Department; (10-1-94)

f. The individual or agency follows the written procedures for service coordination authorized and adhered to by the Department; (10-1-94)

g. Adheres to the Department's mission and value statements; and (10-1-94)

h. Adheres to the Department's contract requirements, billing, and reimbursement procedures. (10-1-94)

04. TSC Provider Staff Qualifications. All individual service coordinators must be employees or contractors of an organized provider agency that has a valid provider agreement/contract with the Department. The employing entity will supervise the individual service coordinators and assure that the following qualifications are met for each individual service coordinator: (10-1-94)

a. Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.; Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners; and (10-1-94)

b. Must have documentation of at least eighteen (18) months, at an average of twenty (20) hours per week, of on-the-job experience providing service to the target population, or be working under the supervision of a fully qualified service coordinator; and (10-1-94)

c. A criminal history check with finger printing shall be obtained; and (10-1-94)

d. Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the recipient's needs are not met; provider agencies will supervise their service coordinators; and (10-1-94)

e. Cannot be the service coordinator for any recipient for whom the service coordinator has individual responsibility for the provision of any other care or treatment; and (10-1-94)

f. Cannot be responsible for the service coordination of more than fifty (50) individuals when using one or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any recipient served by the service coordinator. A waiver of the caseload limit may be granted by the Regional ACCESS Unit on a case by case basis and must meet the following criteria: (5-24-95)

i. The availability of service coordinators is not sufficient to meet the needs of the service area; or (10-1-94)

ii. The recipient who has chosen a particular service coordinator who has reached their limit, has just cause to need that particular provider over other available providers; or (10-1-94)

- iii. The individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) consumers. (10-1-94)
- iv. The request for waiver must include: (10-1-94)
 - (1) The time period for which the waiver is requested; and (10-1-94)
 - (2) The alternative caseload limit requested; and (10-1-94)
 - (3) Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and welfare of any of the service coordinator's consumers. (10-1-94)
- v. The Bureaus may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of TSC services provided. (10-1-94)
- g. Paraprofessionals may be used to assist in the implementation of the ISP. Paraprofessionals must meet the following qualifications: (10-1-94)
 - i. Must be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); and (1-7-94)
 - ii. Must be able to read and write at a level commensurate with the general flow of paperwork and forms; and (1-7-94)
 - iii. Must complete a training program developed by the Division of Family and Community Services and be working under the supervision of a fully qualified service coordination; and (10-1-94)
 - iv. A criminal background check will be obtained. (10-1-94)
- 05. Recipient's Choice. The choice of whether or not to receive TSC services will be the eligible recipient's. All recipients who choose TSC services will have free choice of authorized TSC providers, as well as, the providers of medical and other services under the Medicaid Program. (10-1-94)
- 06. Payment for Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as TSC services, however the actual provision of the services does not constitute TSC. Medicaid will only reimburse for core services (Subsection 118.02) provided to members of the eligible target group by qualified staff. (10-1-94)
 - a. Payment for TSC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)
 - b. Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MRs, or hospitals. (10-1-94)
 - i. Medicaid will reimburse for TSC on the same date a recipient is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of the service delivery. (10-1-94)
 - ii. TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility. (10-1-94)
 - c. Reimbursement for TSC services shall be made on a fee-for-service basis for service provided as established by the Department. (10-1-94)
 - d. The Department will not provide Medicaid reimbursement for on-going TSC services delivered

prior to the completion of assessments and ISP. (10-1-94)

e. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and ISP. (10-1-94)

f. Medicaid reimbursement will be provided only for the following TSC services: (10-1-94)

i. Face-to-face contact between the service coordinator and the recipient, the recipient's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

ii. Telephone contact between the service coordinator and the recipient, the recipient's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

iii. Development, review, revision of the ISP. (10-1-94)

g. The provider will provide the Department with access to all information required to review compliance with these rules. (1-7-94)

h. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (1-7-94)

i. The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals. (10-1-94)

j. The TSC agency must release all pertinent information to direct service providers when written informed consent is obtained from the recipient. (5-24-95)

07. Record Requirements. In addition to the development and maintenance of the ISP, the following documentation must be maintained by the provider: (10-1-94)

a. Name of recipient; (1-7-94)

b. Name of provider agency and person providing the service; (1-7-94)

c. Date, time, and duration of service; (1-7-94)

d. Place of service delivery; (1-7-94)

e. Activity record describing the service(s) provided; (1-7-94)

f. Documented review of progress toward each service plan goal, and assessment of the recipient's need for TSC and other services as the recipient's needs change; (10-1-94)

g. Documentation justifying the provision of crisis assistance to the recipient; and (1-7-94)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of TSC. (10-1-94)

119. REHABILITATIVE SERVICES--RELATED SERVICES PROVIDED BY SCHOOL DISTRICTS.

The Department will pay for rehabilitative related services pursuant to 42 CFR 440.130 (d), including medical or remedial services provided by school districts or other cooperative service agency (as defined in Idaho Code 33.317) which have entered into a provider agreement with the Department. Educational services, other than those "related services" found in 34 CFR 300.16, are the responsibility of the public schools and are not eligible for Medicaid payments. (10-22-93)

01. Recipient Eligibility. To be eligible for medical assistance reimbursement for covered services, a

student shall: (10-22-93)

a. Be identified as having an educational disability pursuant to IDAPA 08, Title 02, Chapter 05, Section 240, "Instructional Programs and Textbooks". Department of Education standards for the education of disabled students; and (10-22-93)

b. Have an Individual Educational Program (IEP) plan which indicates the need for one (1) or more medically necessary related services; and (10-22-93)

c. Be less than twenty-two (22) years of age; and (10-22-93)

d. Be eligible for Medicaid; and (10-22-93)

e. Be served by a school district that is an enrolled medical assistance provider pursuant to these rules. (10-22-93)

02. Evaluation and Diagnostic Services. (10-22-93)

a. Evaluations completed shall: (10-22-93)

i. Be recommended or referred by a physician; and (10-22-93)

ii. Be conducted by qualified professionals for the respective discipline as defined in Subsections 119.05.a. through 119.05.d.; and (10-22-93)

iii. Be directed toward a diagnosis; and (10-22-93)

iv. Identify accurate, current and relevant student strengths, needs, and interests; and (10-22-93)

v. Recommend interventions to address each need. (10-22-93)

b. All initial evaluations must be completed within thirty (30) days of the date parental consent is obtained. Subsequent (e.g. annual) evaluations do not require new parent consent, but only written notice to the parent(s). If the initial evaluation is not completed within this time frame the student's record must contain client-based documentation justifying the delay. (10-22-93)

03. Payable Services. Schools may bill for the following related services provided to eligible students when provided under the recommendation of a physician: (10-22-93)

a. Speech evaluation, individual and group therapy; (10-22-93)

b. Audiology evaluation, individual and group therapy; (10-22-93)

c. Physical/occupational therapy evaluations, individual and group therapy; (10-22-93)

d. Psychological evaluations, individual and group therapy; (10-22-93)

e. Social history and evaluations; and (10-22-93)

f. Annual IEP plan development. (10-22-93)

04. Excluded Services. The following services are excluded from Medicaid payments to school based programs: (10-22-93)

a. Vocational services; and (10-22-93)

b. Educational services (other than related services) or education-based costs normally incurred to

operate a school and provide an education; and (10-22-93)

c. Recreational services. (10-22-93)

05. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (10-22-93)

a. Speech evaluation and therapy: A person qualified to conduct speech/language evaluation and therapy who possesses a certificate of clinical competency in speech-language pathology or who will be eligible for certification within one (1) year of employment. Certification shall be from the American Speech Language and Hearing Association (ASHA). (10-22-93)

b. Audiology evaluation and therapy: A person qualified to conduct hearing evaluation and therapy, who possesses a certificate of clinical competency in audiology or who will be eligible for certification within one (1) year of employment. Certification shall be from the American Speech, Language and Hearing Association (ASHA). (10-22-93)

c. Physical/occupational therapy evaluation and therapy: (10-22-93)

i. Physical therapy: A person qualified to conduct physical therapy evaluations and therapy, who is registered to practice in Idaho. (10-22-93)

ii. Occupational therapy: A person qualified to conduct occupational therapy evaluations and therapy, who is certified by the American Occupational Therapy Certification Board and licensed to practice in Idaho. (10-22-93)

d. Psychological evaluation and therapy: A person who is qualified to provide psychological evaluation and therapy, who is licensed to practice (or is an approved service extender) in Idaho in one of the following disciplines: (10-22-93)

i. Psychiatrist, M.D.; or (10-22-93)

ii. Physician, M.D.; or (10-22-93)

iii. Psychologist, Ph.D., Ed.D, M.A./M.S.; or (10-22-93)

iv. Social Worker; or (10-22-93)

v. Registered Nurse. (10-22-93)

e. Social history and evaluation: A person who is licensed and qualified to provide social work in the state of Idaho; a registered nurse; psychologist; or M.D. (10-22-93)

06. Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by the school to provide related services (except psychotherapy) if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician. The portions of the treatment plan which can be delegated to the paraprofessional, as well as amount and scope of the supervision by the professional must be identified in the IEP. (10-22-93)

a. Paraprofessionals shall not conduct student evaluations or establish the IEP goals. (10-22-93)

b. The professional must have assessed the competence of the paraprofessional (aide) to perform assigned tasks. (10-22-93)

c. The paraprofessional, on a monthly basis, shall be given orientation and training on the program and procedures to be followed. (10-22-93)

- d. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates. (10-22-93)
- e. Any changes in the student's condition not consistent with planned progress or treatment goals necessitates a documented reevaluation by the professional before further treatment is carried out. (10-22-93)
- f. If the paraprofessional works independently there shall be a review conducted by the appropriate professional at least once per month. This review will include the dated initials of the professional conducting the review. (10-22-93)
- g. In addition to the above, if a paraprofessional is utilized to assist in the provision of actual physical therapy they may do so only when the following conditions are met: (10-22-93)
- i. Student reevaluation must be performed and documented by the supervising PT every five (5) visits or once a week if treatment is performed more than once per day. (10-22-93)
- ii. The number of PTAs utilized in any practice or site, shall not exceed twice in number the full time equivalent licensed PTs. (10-22-93)
07. Payment for Services. Payment for school based related services must be in accordance with rates established by the Department. (10-22-93)
- a. Payment will not be made for services if the state match portion is not in the individual school districts account. (10-22-93)
- b. Providers of services must accept as payment in full the Department's payment for such services and must not bill Medicaid recipient's for any portion of any charges. (10-22-93)
- c. Third party payment resources, not to include other school resources, such as private insurance, must be exhausted before the Department is billed for services. Proof of billing other third party payers is required. (10-22-93)
- d. A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services provided under the school based program and codes. (10-22-93)
- e. Payment for school based related services will not be provided to students who are inpatients in nursing homes or hospitals. (10-22-93)
- f. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (10-22-93)
- g. The provider will grant the Department access to all information required to review compliance with these rules. (10-22-93)
08. Record Requirements. In addition to the evaluations and maintenance of the Individual Educational Plan (IEP), the following documentation must be maintained by the provider: (10-22-93)
- a. Name of student; and (10-22-93)
- b. Name and title of the person providing the service; and (10-22-93)
- c. Date, time, and duration of service; and (10-22-93)
- d. Place of service; and (10-22-93)
- e. Activity record describing the service provided and the student's response to the service; and (10-22-93)

f. Documented review of progress toward each service plan goal at least every one hundred twenty (120) days; and (10-22-93)

g. Documentation of qualifications of providers. (10-22-93)

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES CENTERS.

The Department will pay for rehabilitative services pursuant to 42 CFR 440.130(d), including medical or remedial services provided by facilities which have entered into a provider agreement with the Department and are licensed as developmental disabilities centers by the Division of Medicaid, Bureau of Facility Standards. Effective July 1, 1995, all recipients not currently receiving services from a Developmental Disabilities Center shall do so only as part of an Individual Support Plan (ISP) developed by the client and his targeted service coordinator, if one is selected. If the client chooses not to select a targeted service coordinator, the Developmental Disabilities Center (DDC) must ensure an ISP is developed and submitted to the Regional ACCESS Unit. Recipients receiving services from a Developmental Disabilities Center effective July 1, 1995, shall do so only as a part of an ISP developed by the client and his targeted service coordinator, if one is selected, at the time of their annual review and in no case later than June 30, 1996. If the client chooses not to select a targeted service coordinator, the DDC must ensure an ISP is developed and submitted to the Regional ACCESS Unit. Clients who are Home and Community Based Services Waiver recipients who want and need DDC services shall develop an ISP with their targeted service coordinator and submit that plan to the Regional ACCESS Unit for authorization. Educational services, other than those "related services" found in 34 CFR 300.13 and provided to all eligibles under the State Medical Plan, are the responsibility of the public schools and are not eligible for Medicaid payments. Covered "related services" include: audiology; psychotherapy services; physician services; developmental and occupational therapy; physical therapy; speech pathology and transportation necessary to obtain other covered services. (7-1-95)

01. Evaluation and Diagnostic Services. Evaluation and diagnostic services are not required for adults who obtain services from the center as part of an ISP developed with a targeted service coordinator. (7-1-95)

a. When required medical/social, psychological, speech and hearing, physical, developmental, and occupational therapy evaluations must meet the requirements of IDAPA 16.04.11, "Rules and Minimum Standards Governing Developmental Disabilities Centers," with the following exceptions: (7-1-95)

i. For children being served in a Developmental Disabilities Center under Part H of IDEA (Individuals with Disabilities Education Act), the above evaluations must meet the requirements in Title 16, Chapter 1, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early services Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)

ii. For children being served in a Developmental Disabilities Center under Part B of IDEA, the above evaluations must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.05, "Instructional Programs and Textbooks," Section 240, "Special Education Programs." (5-4-94)

b. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all evaluation or diagnostic services provided in any calendar year. (10-6-88)

02. Treatment Services. Home based as well as center services based treatment services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in an ISP submitted to the Regional ACCESS Unit. (7-1-95)

a. The treatment services must meet the requirements of IDAPA 16.04.11, "Rules and Minimum Standards for Developmental Disabilities Centers," with the following exceptions: (5-4-94)

i. For children being served in a Developmental Disabilities Center under Part H of IDEA, treatment services must meet the requirements in Title 16, Chapter 01, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)

ii. For children being served in a Developmental Disabilities Center under Part B of IDEA, treatment services must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.05.240, "Special Education

- Programs." (5-4-94)
- b. Psychotherapy services limited to a maximum of forty-five (45) hours in a calendar year, and include: (7-1-95)
- i. Individual psychotherapy; (7-1-95)
- ii. Group psychotherapy; (7-1-95)
- iii. Family-centered psychotherapy which must include the recipient and one (1) other family member at any given time. (7-1-95)
- c. Speech and hearing therapy services are limited to two hundred fifty (250) treatment sessions per calendar year. (7-1-95)
- d. Physical therapy services are limited to one hundred (100) treatment visits per calendar year. (7-1-95)
- e. Developmental and occupational therapy services are limited to a maximum of thirty (30) hours per week. (7-1-95)
- f. Collateral contact with individuals directly involved with the recipient of service to expand rehabilitative services into the client's living location. Such contacts will be included in the limitations of hours of treatment service reimbursed by Medicaid. Contacts with such persons for the purpose of future placement, interagency and intra-agency case monitoring, staffings and social service activities are not allowable for Medicaid payment. (10-6-88)
- g. 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 recipient is being transported to and from the center. (10-6-88)
03. Optional Services. (11-22-91)
- a. Consultation for the purpose of prescribing, monitoring, and/or administering medications. These consultations shall be: (11-22-91)
- i. Provided by a physician or licensed nurse practitioner in direct face-to-face contact with the client; and (11-22-91)
- ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified. (7-1-95)
- b. Nursing services for the purpose of supervising, monitoring, and/or administering medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. These services shall be: (11-22-91)
- i. Ordered and supervised by a physician; and (11-22-91)
- ii. Provided by licensed and qualified nursing personnel in direct face-to-face contact with the client; and (11-22-91)
- iii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified. (7-1-95)
- c. Psychiatric evaluations and services for the purpose of establishing a diagnosis, identifying client strengths and needs, and recommending and/or implementing interventions to address each need. These evaluations and services shall be: (11-22-91)

- i. Conducted by a physician in direct face-to-face contact with the client; and (11-22-91)
- ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of service specified. (7-1-95)
- 04. Requirements for Centers. Centers must be licensed as Developmental Disabilities Centers by the Department. Loss of licensure by a center will be cause for termination of all Medicaid program payment for services and termination of the center's provider agreement. (11-22-91)
- 05. Excluded Services. The following services are excluded for Medicaid payments: (10-6-88)
 - a. Vocational services; and (10-6-88)
 - b. Educational services; and (10-6-88)
 - c. Recreational services. (10-6-88)
- 06. Payment Procedures. Payment for center services must be in accordance with rates established by the Department. (11-10-81)
 - a. Providers of services must accept as payment in full the Department's payment for such services and must not bill a MA recipient for any portion of any charges. (11-10-81)
 - b. Third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payors is required. (11-10-81)

121. AMBULATORY SURGICAL CENTER.

The Department will provide Ambulatory Surgical Centers (ASC) services for eligible recipients. Reimbursement and covered medical procedures will be based on Medicare program coverage and payment principles. (9-30-84)

- 01. Facility Approval. The ASC must be surveyed by the Department's Licensure and Certification Section as required by 42 CFR 416.25 through 416.49 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. (9-30-84)
- 02. Provider Agreement. Following Medicare program approval, the Department may enter into a provider agreement with an ASC. No Medicaid payment may be made to any ASC in the absence of such an agreement. Grounds for cancellation of the provider agreement will include, but not be limited to: (9-30-84)
 - a. The loss of Medicare program approval will constitute grounds for cancellation of the Department's provider agreement with the ASC. (9-30-84)
 - b. Identification of any condition which threatens the health or safety of patients by the Department's Licensure and Certification Section will constitute grounds for cancellation of the Department's provider agreement with the ASC. (9-30-84)
- 03. Covered Surgical Procedures. Those surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, the Department may add surgical procedures to the listing developed by the Medicare program as required by 42 CFR 416.65 if the procedures meet the criteria identified in 42 CFR 416.65 (a) and (b). (9-30-84)
 - a. The Department will provide a list of approved procedures to all participating ASCs. (9-30-84)
 - b. Such lists will be updated by the Department as new procedures are approved by the Medicare program. All participating ASCs will be notified by the Department of such changes. (9-30-84)
- 04. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and

supplies necessary to safely care for the patient. Such services are reimbursed as follows: (9-30-84)

a. ASC facility service payments represent reimbursement for the costs of goods and services recognized by the Medicare program as described in 42 CFR, Part 416. Payment levels will be determined by the Department. Any surgical procedure covered by the Department as described in Subsection 121.03 but which is not covered by Medicare will have a reimbursement rate established by the Department. (5-25-93)

b. ASC facility services will include, but not be limited to, the following: (9-30-84)

i. Nursing, technician, and related services; and (9-30-84)

ii. Use of ASC facilities; and (9-30-84)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; and (9-30-84)

and iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (9-30-84)

v. Administration, record-keeping and housekeeping items and services; and (9-30-84)

vi. Materials for anesthesia. (9-30-84)

c. ASC facility services do not include the following services: (9-30-84)

i. Physician services; and (9-30-84)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); and (9-30-84)

iii. Prosthetic and orthotic devices; and (9-30-84)

iv. Ambulance services; and (9-30-84)

v. Durable medical equipment for use in the patient's home; and (9-30-84)

vi. Any other service not specified in Subsection 121.04.b. (12-31-91)

122. VISION SERVICES.

The Department will pay for vision services and supplies in accordance with the guidelines and limitations listed below. All eyeglass frames and lenses provided to Medicaid recipients and paid for by the Medicaid Program will be purchased from the supplier designated by the Department. (7-1-97)

01. Eye Examinations. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct a refractive error. Each eligible MA recipient, 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 (See Section 100). (12-31-91)

02. Lenses. Lenses, single vision or bifocal will be provided when there is documentation that the correction need is equal to or greater than plus or minus one-half (.50) diopters. (10-29-92)

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). (1-1-97)T

b. Scratch resistant coating is required for all plastic and polycarbonate lenses. (1-1-97)T

c. 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. (1-1-97)T

d. Contact lenses will be covered only with documentation that an extreme myopic condition requiring a correction equal to or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme conditions as defined by the Department that preclude the use of conventional lenses. (1-1-97)T

03. Replacement Lenses. Replacement lenses shall be purchased from qualified providers only with documentation of a major visual change as defined by the Department. Statements of major visual change shall include documentation of a visual refraction change of at least one-half (.50) diopter plus or minus. (10-1-91)

04. Frames. Frames will be purchased from qualified providers according to the following guidelines: (10-1-91)

a. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for eligible recipients; (10-1-91)

b. Except when it is documented by the physician that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (10-22-93)

05. Glasses. Replacement of broken, lost, or missing glasses shall be the responsibility of the recipient. (1-1-97)T

06. Payment for Non Covered Services. A Medicaid Provider may receive payment from a Medicaid recipient for vision services that are either not covered by the Idaho Medicaid State Plan, or include special features or characteristics that are desired by the recipient but are not medically necessary. Non covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. (1-1-97)T

123. OPTOMETRIST SERVICES.

Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 040. (12-31-91)

01. Payment Availability. Payment for services included in Subsection 070.02.d. and Section 122 is available to all licensed optometrists. (12-31-91)

02. Provider Agreement Qualifications. Optometrists who have been issued and who maintain certification under the provisions of Sections 54-1501 and 54-1509, Idaho Code, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules. (10-25-88)

124. PROSTHETIC AND ORTHOTIC SERVICES.

The Medical Assistance Program will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by the Department. (10-1-91)

01. Required Physician Orders. Prosthetic and orthotic devices and services will be paid for only if prescribed by a physician and preauthorized by the Department. The following information shall be provided with the physician's orders: (10-1-91)

a. A full description of the services requested; and (10-1-91)

b. Number of months the equipment will be needed and the recipient's prognosis; and (10-1-91)

c. The recipient's medical diagnosis and the condition which requires the use of the prosthetic and/or orthotic services, supplies, equipment and/or modifications; and (10-1-91)

- d. All modifications to the prosthetic or orthotic device must be supported by the attending physician's description on the prescription; and (10-1-91)
- e. Requests lacking the required information shall be denied and returned to the applicant. (10-1-91)
- 02. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services authorized by the Department: (10-1-91)
 - a. A temporary lower limb prosthesis shall be authorized by the Department when documented by the attending physician that it is in the best interest of the recipient's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis shall only be requested after the residual limb size is considered stable; (10-1-91)
 - b. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; (10-1-91)
 - c. All prosthetic and orthotic devices that require fitting shall be provided by an individual who is certified or registered by the American Board for Certification in Orthotics and/or Prosthetics; (10-1-91)
 - d. All equipment that is purchased must be new at the time of purchase. Modification to existing prosthetic and/or orthotic equipment will be covered by the Department; (10-1-91)
 - e. Prosthetic limbs purchased by the Department shall be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the recipient; (10-1-91)
 - f. Prosthetic and/or orthotic equipment actually supplied to the recipient shall be the equipment approved by the Department; (10-1-91)
 - g. Not more than ninety (90) days shall elapse between the time the attending physician orders the equipment and the preauthorization request is presented to the Department for consideration; (10-1-91)
 - h. A reusable prosthetic or orthotic device purchased by the Department will remain the property of the Department and return of the device to the Department may be required when: (10-1-91)
 - i. The recipient no longer requires the use of the device; or (10-1-91)
 - ii. The recipient expires. (10-1-91)
- 03. Program Limitations. The following limitations shall apply to all prosthetic and orthotic services and equipment: (10-1-91)
 - a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and ordered by the attending physician; (10-1-91)
 - b. Refitting, repairs or additional parts shall be limited to once per calendar year for all prosthetics and/or orthotics unless it has been documented that a major medical change has occurred to the limb, and ordered by the attending physician; (10-1-91)
 - c. All refitting, repairs or alterations require preauthorization based on medical justification by the recipient's attending physician; (10-1-91)
 - d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes shall not be covered by the Department. These items include, but are not limited to, breast implants, penile implants and artificial eyes;

(10-1-91)

e. Electronically powered or enhanced prosthetic devices are not covered by the program; (10-1-91)

f. The Department will only authorize corrective shoes or modification to an existing shoe owned by the recipient when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot; (10-1-91)

g. Shoes and accessories such as mismatch shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are not covered under the program; and (10-1-91)

h. Corsets are not a benefit of the program nor are canvas braces with plastic or metal bones. However, special braces enabling a patient to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast. (10-1-91)

04. Billing Procedures. The Department will provide billing instruction to providers of prosthetic or orthotic services. A copy of the preauthorization must be attached to the claim form when submitted. (10-1-91)

05. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04. (12-31-91)

125. DENTAL SERVICES.

01. Dental Services-Listing. Dental services include diagnostic, preventive, restorative treatment, relief of dental pain and are purchased from a licensed dentist. Unspecified procedures will not be covered unless preauthorized. The following specific procedures are included in dental services: (10-1-91)

a. Initial oral exam; and (10-1-91)

b. Recall; and (10-1-91)

c. Full mouth x-rays, including necessary bitewing x-rays; and (10-1-91)

d. Intra-oral periapical, single film, first; and (10-1-91)

e. Intra-oral periapical, each additional film; and (10-1-91)

f. Bitewings; and (10-1-91)

g. Panographic survey; and (12-14-92)

h. Prophylaxis, adult complex; and (10-1-91)

i. Prophylaxis, child to age fifteen (15), simple; and (10-1-91)

j. Topical application of fluoride excluding prophylaxis; and (10-1-91)

k. Space maintainer, fixed, unilateral band or crown type; and (10-1-91)

l. Space maintainer, fixed, bilateral band or crown type; and (10-1-91)

m. Amalgams; and (10-1-91)

n. Retention pins; and (10-1-91)

o. Silicate cement, per restoration; and (10-1-91)

p.	Acrylic or plastic; and	(10-1-91)
q.	Composites; and	(10-1-91)
r.	Crown, jacket, plastic; and	(10-1-91)
s.	Crown, jacket, plastic - prefabricated, crown full - porcelain fused to nonprecious alloy; and	(10-1-91)
t.	Crown, stainless steel; and	(10-1-91)
u.	Dowel pin; and	(10-1-91)
v.	Re-cement crown; and	(10-1-91)
w.	Pulp cap; and	(10-1-91)
x.	Pulpotomy; and	(10-1-91)
y.	Root canal therapy; and	(10-1-91)
z.	Apicectomy, performed as separate surgical procedure;	(10-1-91)
aa.	Complete denture, upper; and	(10-1-91)
bb.	Complete denture, lower; and	(10-1-91)
cc.	Partial denture, upper or lower, with or without clasps, acrylic, flipper-stayplate; and	(10-1-91)
dd.	Denture adjustments; and	(10-1-91)
ee.	Relining or rebasing upper or lower complete denture; and	(12-14-92)
ff.	Extraction, simple; and	(10-1-91)
gg.	Extraction, surgical erupted tooth; and	(10-1-91)
hh.	Extraction, surgical, soft tissue impaction; and	(10-1-91)
ii.	Extraction, surgical, partial bony impaction; and	(10-1-91)
jj.	Extraction, surgical, complete bony impaction; and	(10-1-91)
kk.	Palliative (emergency) treatment of dental pain, minor procedures; and	(10-1-91)
ll.	Pit and fissure sealants.	(10-1-91)
02.	Dental Services-Limitations.	(7-1-93)
a.	All hospitalizations must have prior approval; and	(10-1-91)
b.	Any dental service not listed in the Benefit Schedule is not covered; and	(10-1-91)
c.	Restoration of primary lateral and central incisors after the fifth birthday are not allowed. Teeth numbers D, E, F, G, N, O, P, and Q are the nonallowed teeth; and	(10-1-91)

- d. Space maintainers after the tenth birthday are not a covered benefit; and (10-1-91)
- e. Denture relines not allowed for six (6) months after original placement and then once in a two (2) year period. (12-14-92)
- f. Denture construction no more frequent than every five (5) years; and (10-1-91)
- g. Denture adjustments not allowed for six (6) months following placement by same dentist who provided denture. (12-14-92)
- h. Full mouth x-rays no more frequent than every three (3) years; and (10-1-91)
- i. Panoramic x-rays no more frequent than every twelve (12) months; and (10-1-91)
- j. A maximum of four (4) bitewing x-rays allowed every six (6) months; and (10-1-91)
- k. Restoration of the same tooth, same surface, no more than every two (2) years; and (10-1-91)
- l. Initial oral exams allowed every twelve (12) months; and (10-1-91)
- m. Recall exam allowed once every six (6) months; and (10-1-91)
- n. Oral prophylaxis no more frequent than one (1) every six (6) months; and (10-1-91)
- o. Topical fluoride applications will be allowed every six (6) months; and (10-1-91)
- p. Topical fluoride given as a fluoride paste prophylaxis will be paid as prophylaxis only according to patient's age; and (10-1-91)
- q. Restorative services which are cosmetic in nature are not covered; and (10-1-91)
- r. More than one (1) restoration in the same tooth surface is not covered; and (10-1-91)
- s. Periodontal scaling and root planning covered once in a twelve (12) month period. (12-14-92)
- t. Periodontal maintenance covered once in a six (6) month period. (12-14-92)
- u. Acid etch as a separate procedure is not allowed; and (10-1-91)
- v. Oral hygiene instruction is not a benefit; and (10-1-91)
- w. Medicated bases or liners are not covered as a separate procedure from the restoration; and (10-1-91)
- x. Local anesthetics fees are not covered as a separate charge; and (10-1-91)
- y. Polishing and finishing charges are not covered as a separate charge; and (10-1-91)
- z. Procedures not recognized by the American Dental Association are not covered; and (12-14-92)
- aa. Root canal procedures are limited to permanent teeth; and (10-1-91)
- bb. Fixed bridgework is not covered; and (10-1-91)
- cc. Orthodontic services will be a benefit for EPSDT eligible children under age twenty-one (21) years only with preauthorization as determined by the handicapping malocclusion Index (DHEW Pub. #77-1644). (11-6-93)

- dd. Orthodontic Services are not benefits for persons after their twenty-first (21st) birthday. (12-14-92)
- ee. Occlusal sealants will be limited to permanent molars and premolars for recipients age six (6) years to sixteen (16) years. Service is also limited to once per tooth in a three (3) year period. (11-6-93)
- 03. Dental Services-Procedures. Dental service procedures are as follows: (10-1-91)
 - a. If a dental provider determines that hospitalization is necessary for the dental treatment, a request in writing must be submitted to the Department prior to the hospitalization and written preauthorization received from the Department's dental consultant. (10-1-91)
 - b. If, in the opinion of a dental provider, a condition exists such that orthodontic correction of a severely handicapping malocclusion is vital to the physical and emotional well-being of the individual, a request in writing must be submitted to the Department for prior approval. Supporting evidence of need must be presented and is to include x-rays and plaster casts which demonstrate the severity of the malocclusion (See IDAPA 16, Title 03, Chapter 19, Subsection 025.02.z.). (12-31-91)
 - c. Unspecified procedures can be submitted for review to determine if the procedure can be pre-authorized. X-Rays and written justification are required. (12-14-92)
- 04. Dental Payment Procedure. (12-31-91)
 - a. The Department will pay the lower of either the billed charge or the state's maximum reimbursement rate (See Section 060); (12-31-91)
 - b. All dental claims must be submitted on the American Dental Association (ADA) claim form. (10-1-91)

126. PRESCRIPTION DRUGS.

The Department will pay for those prescription drugs not excluded by Subsection 126.02 which are legally obtainable by the order of a licensed physician, dentist, osteopath, nurse practitioner, or podiatrist. Prescriptions for diaphragms and oral contraceptives as well as contraceptive supplies and intrauterine devices are also eligible for payment under Subsection 090.01. (12-31-91)

- 01. Financial Obligations of Recipients. Recipients who obtain a quantity of medication exceeding that allowed in Subsection 126.04 are responsible for payment to the pharmacy of all charges applicable to the additional quantities. This recipient responsibility applies whether or not the charges are produced by one (1) or multiple dispensing incidents. (12-31-91)
- 02. Excluded Drug Products. The following categories and specific products are excluded: (2-4-91)
 - a. Non-legend medications unless included in Subsection 126.03.b. This includes legend medications that change to non-legend status as well as their therapeutic equivalents regardless of prescription status; and (12-31-91)
 - b. Any legend drugs for which federal financial participation is not available; and (9-15-83)
 - c. Diet supplements; and (11-10-81)
 - d. Amphetamines, anorexiant, and related products, including, but not limited to: (11-10-81)
 - i. Amphetamine; and (1-16-80)
 - ii. Benzphetamine; and (1-16-80)
 - iii. Chlorphentermine; and (1-16-80)

- iv. Chlortermine; and (1-16-80)
- v. Dextroamphetamine; and (1-16-80)
- vi. Diethylpropion; and (1-16-80)
- vii. Fenfluramine; and (1-16-80)
- viii. Mazindol; and (1-16-80)
- ix. Methamphetamine; and (1-16-80)
- x. Phendimetrazine Tartrate; and (1-16-80)
- xi. Phenmetrazine; and (1-16-80)
- xii. Phentermine; and (1-16-80)
- xiii. Salts and optical isomers of the above listed drugs; and (1-16-80)
- xiv. Combination products containing any of the above drugs. (1-16-80)
- e. Ovulation stimulants including Clomiphene Citrate, Menotropins, and Urofollitropin; and (2-4-91)
- f. Topical Minoxidil; and (11-10-87)
- g. Nicotine chewing gum and transdermal patches; and (2-4-91)
- h. Isotretinoin; and (11-10-87)
- i. Topical medications whose active ingredients include either: (11-10-87)
- i. Benzoyl peroxide combinations; (11-10-87)
- ii. Clindamycin; (11-10-87)
- iii. Erythromycin; (11-10-87)
- iv. Meclomycin; (11-10-87)
- v. Tetracycline; (11-10-87)
- vi. Tretinoin except when prior authorized for squamous metaplasia of ocular surface epithelia. (11-10-87)
- j. Vitamins unless included in Subsection 126.03.a. (12-31-91)
- 03. Additional Covered Drug Products. Additional drug products will be allowed as follows: (2-4-91)
- a. Therapeutic Vitamins; (2-4-91)
- i. Injectable vitamin B12 (cyanocobalamin and analogues); and (2-4-91)
- ii. Vitamin K and analogues; and (1-16-80)
- iii. Pediatric vitamin-fluoride preparations; and (1-16-80)

- iv. Legend prenatal vitamins for women of child bearing age; and (1-16-80)
- v. Legend Folic acid; and (2-4-91)
- vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (2-4-91)
- vii. Legend vitamin D and analogues. (2-4-91)
- b. Prescriptions for nonlegend products. (2-4-91)
 - i. Insulin; and (2-4-91)
 - ii. Disposable insulin syringes and needles; and (2-4-91)
 - iii. Oral iron salts. (2-4-91)
- 04. Limitation of Quantities. No more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (11-10-81)
 - a. Up to one hundred (100) doses of medication may be purchased regardless of the prescribed dosage schedule for: (1-16-80)
 - i. Cardiac glycosides; and (1-16-80)
 - ii. Thyroid replacement hormones; and (1-16-80)
 - iii. Prenatal vitamins; and (1-16-80)
 - iv. Nitroglycerin products; and (1-16-80)
 - v. Fluoride and vitamin/fluoride combination products; and (2-4-91)
 - vi. Nonlegend oral iron salts. (2-4-91)
 - b. Oral contraceptive products will be purchased in a quantity sufficient for one (1), two (2), or three (3) cycles. (1-16-80)
- 05. Comparative Cost to Be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs. (11-10-81)
- 06. Dispensing Procedures. (11-10-81)
 - a. To obtain a prescription drug, a MA recipient must present his identification card to a participating pharmacy together with a prescription from a licensed physician, dentist, osteopath, nurse practitioner, or podiatrist. (11-10-81)
 - b. Refills of prescription drugs must be authorized by the prescriber and recorded on the prescription or on the recipient's medication profile by pharmacists. (11-10-81)
 - c. The Idaho Medical Assistance Drug Program requires that MA prescriptions be dispensed according to the rules, Chapter 17, Title 54, Idaho Code; Chapter 27, Title 37, Idaho Code; the Idaho Uniform Controlled Substances Act; and Idaho State Board of Pharmacy Rules. (11-10-81)
 - d. Prescriptions not filled in accordance with the provisions of Section 126 will be subject to

nonpayment or recoupment. (12-31-91)

e. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for utilization review purposes by the Department with a minimum of twenty-four (24) hours prior notification. (11-10-81)

07. Payment Procedures. (11-10-81)

a. Pharmacists must file claims by submitting the appropriate claim form to the Department. Upon request, the Department will provide pharmacies with a supply of claim forms and instructions. The form submitted must include the following information: (11-10-81)

i. Patient's name and identification number; and (11-10-81)

ii. The medication, prescriber, quantity of drug dispensed, and the usual and customary charge for each particular prescription. (11-10-81)

b. Each claim form is subject to review by a Medical Claim Examiner, a Pharmaceutical Consultant, and a Medical Consultant. (11-10-81)

c. Pharmacists' billed charges are not to exceed the usual and customary charges to the general public for the same product and quantity. (1-16-80)

d. Reimbursement to pharmacies must be limited to the lowest of the following costs: (1-16-80)

i. Maximum Allowable Cost (MAC), as established by the Pharmaceutical Reimbursement Board, U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; or (11-10-81)

ii. Estimated Acquisition Cost (EAC), as established by the Department plus the assigned dispensing fee; or (1-16-80)

iii. The pharmacy's usual and customary charge to the general public. (1-16-80)

e. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient in a long term nursing care facility except: (11-10-81)

i. For the multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence indicates that the quantity issued at each dispensing incident does not relate to the recipient's known monthly requirements for that specific medication; and (11-10-81)

ii. For oral liquid maintenance drugs if a reasonable quantity, as determined by the Department, is dispensed at each filling; and (11-10-81)

iii. If a thirty-four (34) day supply of the drug is excessive, in the judgment of the Department. (11-10-81)

f. Claims are processed by computer and payments are made directly to the pharmacy. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (11-10-81)

127. DENTURIST SERVICES.

01. Payment. Payment will be available for the following specific procedures when provided by licensed denturists who are participating providers in the Medicaid Program: (3-1-92)

a. Complete denture, upper; (3-1-92)

- b. Complete denture, lower; (3-1-92)
- c. Immediate denture, upper; (3-1-92)
- d. Immediate denture, lower; (3-1-92)
- e. Adjust complete denture, upper; (3-1-92)
- f. Adjust complete denture, lower; (3-1-92)
- g. Adjust partial denture, upper; (3-1-92)
- h. Adjust partial denture, lower; (3-1-92)
- i. Repair broken complete denture base; (3-1-92)
- j. Replace missing or broken teeth, complete denture (each tooth); (3-1-92)
- k. Repair resin saddle or base; (3-1-92)
- l. Repair cast framework; (3-1-92)
- m. Repair or replace broken clasp; (3-1-92)
- n. Repair broken teeth per tooth; (3-1-92)
- o. Add tooth to existing partial denture; (3-1-92)
- p. Add clasp to existing partial denture; (3-1-92)
- q. Reline complete upper denture (chairside); (3-1-92)
- r. Reline complete lower denture (chairside); (3-1-92)
- s. Reline upper partial denture (chairside); (3-1-92)
- t. Reline lower partial denture (chairside); (3-1-92)
- u. Reline complete upper denture (laboratory); (3-1-92)
- v. Reline complete lower denture (laboratory); (3-1-92)
- w. Reline upper partial denture (laboratory); (3-1-92)
- x. Reline lower partial denture (laboratory); (3-1-92)
- 02. Denturist Services -- Limitations. Denture construction is covered no more frequently than every five (5) years. (3-1-92)
- 03. Payment Procedure. (3-1-92)
 - a. The Department will pay the lower of either the billed charge or the Department's maximum reimbursement rate (see Section 060). (3-1-92)
 - b. All claims must be submitted on the American Dental Association (ADA) claim form. (3-1-92)

128. DIABETES EDUCATION AND TRAINING SERVICES.

01. Education and Training Conditions. Outpatient diabetes education and training services will be covered under the following conditions: (1-1-97)T

a. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association. (1-1-97)T

b. The education and training services are provided through a formal program conducted through a hospital outpatient department, or through a physician's office, only by a Certified Diabetic Educator. (1-1-97)T

c. For purposes of this section, a Certified Diabetes Educator is a state licensed health professional who is identified as a Certified Diabetes Educator according to the national standards set forth by the National Certification Board for Diabetes Educators. (1-1-97)T

02. Service Description. Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. (1-1-97)T

03. Diabetes Counseling. To receive diabetes counseling, the following conditions apply to each patient: (1-1-97)T

a. The patient must have written order by his or her primary care physician or physician extender referring the patient to the program. (1-1-97)T

b. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents. (1-1-97)T

c. The medical necessity for diabetes education and training are evidenced by the following: (1-1-97)T

i. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or, (1-1-97)T

ii. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c [greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or, (1-1-97)T

iii. Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (1-1-97)T

d. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (1-1-97)T

04. Reimbursement. Diabetes education and training services will be reimbursed according to the Department's established fee schedule. (1-1-97)T

129. (RESERVED).

130. INDIAN HEALTH SERVICE CLINICS.

01. Care and Services Provided. Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Sections 050 through 155.

(12-31-91)

02. Payment Procedures.

(7-1-93)

a. Payment for services other than prescribed drugs and dental services will be made on a per visit basis at a rate not exceeding the out-patient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. (11-10-81)

b. Payment for prescribed drugs will be available as described in Section 126.

(12-31-91)

c. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (11-10-81)

d. Payment for dental services will be made on a fee-for-service basis as described in Subsections 100.03 through 100.05. (12-31-91)

e. The provisions of Section 030, "Third Party Liability," are not applicable to Indian health service clinics. (12-31-91)

131. -- 134. RESERVED).

135. CHIROPRACTIC SERVICES.

The Department will pay for a total of two (2) office visits during any calendar month for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition demonstrated to exist by x-ray. (9-1-82)

136. -- 139. (RESERVED).

140. PHYSICAL THERAPY SERVICES.

The Department will pay for physical therapy rendered by or under the supervision of a licensed physical therapist if such services are ordered by the attending physician as part of a plan of care. ()

01. Service Description. The following 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), published by the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, most current edition, are reimbursable for physical therapists. ()

a. Modalities are any physical agent applied to produce therapeutic changes to biological tissue. These include the application of thermal, acoustic, light, mechanical or electrical energy. CPT procedure code range 97032 through 97036 require direct, one to one, patient contact by the therapist. CPT procedure code range 97010 through 97028 may be performed under the supervision of the physical therapist. Any modality which is not contained in these procedure code ranges must be billed using CPT code 97039 for an unlisted modality, and requires authorization by the Department prior to payment. In this case, physician and therapist information documenting the medical necessity of the modality requested for payment must be provided in writing to the Bureau of Medicaid Policy and Reimbursement. ()

b. Therapeutic procedures are the application of clinical skills, services, or both that attempt to improve function. All therapeutic procedures require the therapist to have direct, one to one, patient contact. CPT procedure code range 97110 through 97541, and 97770, but excluding CPT procedure code 97124, massage, are eligible for Medicaid payment. Any procedure not described by these procedure codes must be billed using CPT procedure code 97139 as an unlisted procedure, and requires authorization by the Department prior to payment. In this case, physician and therapist documentation of the medical necessity of the therapeutic procedure must be provided in writing to the Bureau of Medicaid Policy and Reimbursement. ()

c. The provision of tests or measurements as described by CPT procedure codes 97700 through 97750

may be reimbursed. The physical therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography or nerve velocity determinations as described in CPT procedure codes 95831 through 95904 when ordered by a physician. ()

02. Physician Orders. All physical therapy must be ordered by a physician and such orders must include at a minimum, the service to be provided, frequency, and, where applicable, the duration of each therapeutic session. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every thirty (30) days for all patients except those receiving home health agency services. Physical therapy provided by home health agencies must be included in the home health plan of care and be reordered not less often than every sixty (60) days. Documentation including the physician orders, care plans, progress or other notes documenting each assessment, therapy session and testing or measurement results must be maintained in the files of the therapist. The absence of such documentation is cause for recoupment of Medicaid payment. ()

03. Payment Procedures. Payment procedures are as follows: ()

a. Each recipient is limited to one hundred (100) visits of outpatient physical therapy during any calendar year. Visits to outpatient departments of hospitals and from home health agencies or independent physical therapists providing physical therapy are included in the limit on the total outpatient physical therapy visits. (3-22-93)

b. Home health agencies must send a copy of the patient's attending physician's order for physical therapy services to the Department with their claims. ()

i. Physical therapy rendered by home health agencies must have, at least every sixty (60) days, physician recertification, in writing, that those services were medically necessary. This information must be on the copy of the physician's order submitted with the claim. ()

ii. Physical therapy provided by home health agencies will be paid at a rate per visit as described in Section 105. (12-31-91)

c. Physical therapists identified by Medicare as independent practitioners and enrolled as Medicaid providers will be paid on a fee-for-service basis. The maximum fee paid will be based upon the Department's fee schedule. Only these practitioners can bill the Department directly for their services. ()

d. Physical therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (3-22-93)

e. Physical therapy rendered by nursing home facilities to outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (7-1-85)

f. Payment for physical therapy rendered to inpatients in long-term care facilities is made directly to the facilities as part of their operating costs. (7-1-85)

g. Payment for physical therapy ordered in an Adult and Child Development Center or its equivalent, according to Section 120, will be made directly to that center. Payment will be based upon the Department's fee schedule for those services. (12-31-91)

04. Excluded Services. Services excluded from Medicaid program coverage include Hippotherapy, group exercise therapy, group hydrotherapy, and biofeedback services. ()

141. -- 142. (RESERVED).

143. WAIVER SERVICES FOR ADULT DEVELOPMENTALLY DISABLED RECIPIENTS.

Pursuant to 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible recipients in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to achieve and maintain community integration. For a recipient to be eligible, the Department must find that the recipient requires services due to a

developmental disability which impairs their mental or physical function or independence, be capable of being maintained safely and effectively in a non-institutional setting and would, in the absence of such services, need to reside in an ICF/MR. (7-1-95)

01. Services Provided. (7-1-95)

a. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible recipients 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: (7-1-97)

i. 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: (7-1-97)

(1) 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; (7-1-95)

(2) Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-95)

(3) 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; (7-1-95)

(4) Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the recipient to their community. (Socialization training associated with participation in community activities includes assisting the recipient to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the recipient to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature); (7-1-95)

(5) 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; (7-1-95)

(6) 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. (7-1-95)

ii. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the recipient or the recipient's primary caregiver(s) are unable to accomplish on his own behalf. (7-1-95)

iii. Skills training to teach waiver recipients, family members, alternative family caregiver(s), or a recipient'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. (7-1-95)

b. 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 recipient's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the recipient, 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 payor 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 recipient. (7-1-95)

c. Respite care services which are those services provided, on a short term basis, in the home of either the waiver recipient or respite provider, to relieve the person's family or other primary caregiver(s) from daily stress and care demands. While receiving respite care services, the waiver recipient cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to recipients who reside with non-paid caregivers. (7-1-95)

d. 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. (7-1-95)

i. 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/funded under the Rehabilitation Act of 1973 as amended, or IDEA; and the waiver participant has been deinstitutionalized from an NF or ICF/MR at some prior period. (7-1-95)

ii. 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 recipients 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. (7-1-95)

e. Transportation services which are services offered in order to enable waiver recipients to gain access to waiver and other community services and resources required by the individual support plan. 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 shall 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. (7-1-95)

f. Environmental modifications which are those interior or exterior physical adaptations to the home, required by the waiver recipient's support plan, 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 recipient 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 recipient, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, or central air conditioning. All services shall 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 recipient or the recipient's family when the home is the recipient's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the recipient to his next place of residence or be returned to the Department. (7-1-95)

g. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the Individual Support Plan which enable recipients 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 shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation. (7-1-95)

h. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver recipient safety and/or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to recipients 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. (7-1-95)

i. Home delivered meals which are designed to promote adequate wavier recipient nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to recipients 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. (7-1-97)

j. Therapy services under the waiver include physical therapy services; occupational therapy services; and speech, hearing and language services. These services are to be available through the waiver when the need for such services exceeds the therapy limitations under the State plan. Under the waiver, therapy services will include: (7-1-97)

i. Services provided in the waiver recipient's residence, day habilitation site, or supported employment site; (7-1-95)

ii. Consultation with other service providers and family members; (7-1-95)

iii. Participation on the recipient's Individual Support Plan team. (7-1-97)

k. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the Individual Support Plan which are within the scope of the Nurse Practice Act and are provided by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. (7-1-95)

l. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of recipients 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 recipient. These services also provide emergency back-up involving the direct support of the recipient in crisis. (7-1-97)

02. Place of Service Delivery. Waiver services for developmentally disabled recipients may be provided in the recipient's personal residence, specialized family home, waiver facilities, day habilitation/supported employment program or community. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (7-1-95)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-95)

b. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-95)

c. Licensed Residential Care Facility; and (7-1-95)

d. Adult foster homes. (7-1-95)

e. Additional limitations to specific services are listed under that service definition. (7-1-95)

03. Services Delivered Following a Written Plan. All waiver services must be authorized by the ACCESS Unit in the Region where the recipient will be residing and provided based on a written Individual Support Plan (ISP). (7-1-95)

a. The ISP is developed by the ISP team which includes: (7-1-95)

- i. The waiver recipient. Efforts must be made to maximize the recipient's participation on the team by providing him with information and education regarding his rights; and (7-1-95)
- ii. The service coordinator chosen by the recipient; and (7-1-95)
- iii. The guardian when appropriate; and (7-1-95)
- iv. May include others identified by the waiver recipient. (7-1-95)
- b. The ISP must be based on a person centered planning and assessment process approved by the Department. (7-1-95)
- c. The ISP must include the following: (7-1-95)
 - i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and (7-1-95)
 - ii. Supports and service needs that are to be met by the recipient's family, friends and other community services; and (7-1-95)
 - iii. The providers of waiver services when known; and (7-1-95)
 - iv. Documentation that the recipient has been given a choice between waiver services and institutional placement; and (7-1-95)
 - v. The signature of the recipient or his legal representative and the service coordinator. (7-1-95)
- d. The plan must be revised and updated by the ISP team based upon treatment results or a change in the recipient's needs, but at least semi-annually. A new plan must be developed and approved annually. (7-1-95)
- 04. Authorization of Services. All services reimbursed under the Home and Community Based Waiver for Developmentally Disabled must be authorized prior to the payment of services by the Regional ACCESS Unit. (7-1-95)
- 05. Service Supervision. The Individual Support Plan which includes all waiver services is monitored by the service coordinator. (7-1-95)
- 06. Provider Qualifications. All providers of waiver services must have a valid provider agreement/ performance contract with the Department. Performance under this agreement/contract will be monitored by the ACCESS Unit in each region. (7-1-95)
 - a. Residential Habilitation services must be provided by an agency that is certified as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," that has been certified by the Department and capable of supervising the direct services provided. Independent providers of personal care services that are transferred to providers of residential habilitation services under this waiver shall either work for an agency or affiliate with an agency to provide oversight, training and quality assurance. If there is no agency available in a geographic location, providers of residential habilitation services under this waiver will not be required to work for or affiliate with an agency until one becomes available. Providers of residential habilitation services must meet the following requirements: (7-1-97)
 - i. Direct service staff must meet the following minimum qualifications: be at least eighteen (18) years of age; be a high school graduate or have a GED or demonstrate the ability to provide services according to an Individual Support Plan; have current CPR and First Aid certifications; be free from communicable diseases; pass a criminal background check (when residential habilitation services are provided in a specialized family home, all adults living in the home must pass a criminal background check); participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver

participants, and handling of confidential and emergency situations that involve the waiver participant, provided by the agency prior to performing services; have appropriate certification or licensure if required to perform tasks which require certification or licensure. (7-1-95)

ii. The provider agency will be responsible for providing training specific to the needs of the recipient. Skill training must be provided by a Qualified Mental Retardation Professional who has demonstrated experience in writing skill training programs. Additional training requirements must include at a minimum: instructional technology; behavior technology; feeding; communication/sign language; mobility; assistance with medications (training in assistance with medications must be provided by a licensed nurse); activities of daily living; body mechanics and lifting techniques; housekeeping techniques and maintenance of a clean, safe, and healthy environment. (7-1-95)

iii. Residential habilitation providers who are unable to join or affiliate with an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a Qualified Mental Retardation Professional (QMRP) who has a valid provider agreement with the Department. (7-1-95)

iv. When residential habilitation services are provided in the provider's home, the agency or independent provider must meet the environmental sanitation standards; fire and life safety standards; and building, construction and physical home standards for certification as an Adult Foster Home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (7-1-95)

b. Providers of chore services must meet the following minimum qualifications: (7-1-95)

i. Be skilled in the type of service to be provided; and (7-1-95)

ii. Demonstrate the ability to provide services according to an individual support plan. (7-1-95)

c. Providers of respite care services must meet the following minimum qualifications: (7-1-95)

i. Meet the qualifications prescribed for the type of services to be rendered, for instance Residential Habilitation providers, or must be an individual selected by the waiver participant and/or the family or guardian; and (7-1-95)

ii. Have received caregiving instructions in the needs of the person who will be provided the service; and (7-1-95)

iii. Demonstrate the ability to provide services according to an individual support plan; and (7-1-95)

iv. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; and (7-1-95)

v. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (7-1-95)

vi. Be free of communicable diseases. (7-1-95)

d. 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 (7-1-95)

e. Providers of transportation services must: (7-1-95)

i. Possess a valid driver's license; and (7-1-95)

ii. Possess valid vehicle insurance. (7-1-95)

- f. Environmental Modifications services must: (7-1-95)
 - i. Be done under a permit, if required; and (7-1-95)
 - ii. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-95)
- g. Specialized Equipment and Supplies purchased under this service must: (7-1-95)
 - i. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-95)
 - ii. Be obtained or provided by authorized dealers of the specific product where applicable. For instance, medical supply businesses or organizations that specialize in the design of the equipment. (7-1-95)
- h. Personal Emergency Response Systems must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (7-1-95)
- i. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-95)
 - i. 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; and (7-1-95)
 - ii. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (7-1-95)
 - iii. 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; and (7-1-95)
 - iv. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; and (7-1-95)
 - v. Provide documentation of current driver's license for each driver; and (7-1-95)
 - vi. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-95)
- j. All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan. (7-1-95)
- k. Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing. (7-1-95)
 - l. Behavior Consultation/Crisis Management Providers must meet the following: (7-1-95)
 - i. 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 (7-1-95)
 - ii. 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 (7-1-95)
 - iii. Be a licensed pharmacist; or (7-1-95)

- iv. Be a Qualified Mental Retardation Professional. (7-1-97)
- v. Emergency back-up providers must meet the minimum provider qualifications under Residential Habilitation services. (7-1-95)
- 07. Recipient Eligibility Determination. Waiver eligibility will be determined by the Regional ACCESS Unit. The recipient must be financially eligible for MA as described in IDAPA 16.03.05.634, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)." The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver recipients must meet the following requirements: (7-1-97)
 - a. The Regional ACCESS Unit must determine that: (7-1-95)
 - i. The recipient would qualify for ICF/MR level of care as set forth in Section 180 of these rules, if the waiver services listed in Section 143 of these rules were not made available; and (7-1-95)
 - ii. The recipient could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the ISP team; and prior to any denial of services on this basis, be determined by the Service Coordinator that services to correct the concerns of the team are not available. (7-1-95)
 - iii. The average daily cost of waiver services and other medical services to the recipient would not exceed the average daily cost to Medicaid of ICF/MR care and other medical costs. Individual recipients whose cost of services exceeds this average may be approved on a case by case basis that assures that the average per capita expenditures under the waiver do not exceed one hundred percent (100%) of the average per capita expenditures for ICF/MR care under the State plan that would have been made in that fiscal year had the waiver not been granted. This approval will be made by a team identified by the Administrators of the Divisions of Medicaid and Family and Community Services. (7-1-97)
 - iv. Following the approval by the ACCESS Unit for services under the waiver, the recipient must receive and continue to receive a waiver service as described in these rules. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-95)
 - b. A recipient who is determined by the ACCESS Unit to be eligible for services under the Home and Community Based Services Waiver for developmentally disabled may elect to not utilize waiver services but may choose admission to an ICF/MR. (7-1-95)
 - c. The recipient's eligibility examiner will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the eligibility examiner will forward potentially eligible applications immediately to the ACCESS Unit for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (7-1-97)
 - d. The decisions of the ACCESS Unit regarding the acceptance of the recipients into the waiver program will be transmitted to the eligibility examiner. (7-1-95)
- 08. Case Redetermination. (7-1-95)
 - a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Rules Governing Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the ACCESS Unit, or sooner at the request of the recipient, the eligibility examiner, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. (7-1-97)
 - b. The redetermination process will assess the following factors: (7-1-95)
 - i. The recipient's continued need for waiver services; and (7-1-95)

- ii. Discharge from the waiver services program. (7-1-97)
- 09. Provider Reimbursement. (7-1-95)
 - a. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-95)
 - b. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-95)
 - c. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the recipient's home or other service delivery location when the recipient is not being provided transportation. (7-1-95)
- 10. Provider Records. Three (3) types of record information will be maintained on all recipients receiving waiver services: (7-1-97)
 - a. Direct Service Provider Information which includes written documentation of each visit made or service provided to the recipient, and will record at a minimum the following information: (7-1-95)
 - i. Date and time of visit; and (7-1-95)
 - ii. Services provided during the visit; and (7-1-95)
 - iii. A statement of the recipient's response to the service, if appropriate to the service provided, including any changes in the recipient's condition; and (7-1-95)
 - iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the recipient is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the recipient as evidenced by their signature on the service record. (7-1-95)
 - v. A copy of the above information will be maintained in the recipient's home unless authorized to be kept elsewhere by the ACCESS Unit. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-97)
 - b. The individual support plan which is initiated by the ACCESS Unit and developed by the Service Coordinator and the ISP team must specify which waiver services are required by the recipient. The plan will contain all elements required by Subsection 143.03 and a copy of the most current individual support plan will be maintained in the recipient's home and will be available to all service providers and the Department. (7-1-95)
 - c. In addition to the individual support plan, at least monthly the service coordinator will verify in writing, that the services provided were consistent with the individual support plan. Any changes in the plan will be documented and include the signature of the service coordinator and when possible, the recipient. (7-1-95)
- 11. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator when any significant changes in the recipient's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-95)
- 12. Records Maintenance. In order to provide continuity of services, when a recipient is transferred among service providers, or when a recipient changes service coordinators, all of the foregoing recipient records will be delivered to and held by the Regional ACCESS Unit until a replacement service provider or service coordinator assumes the case. When a recipient leaves the waiver services program, the records will be retained by the Regional ACCESS Unit as part of the recipient's closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. (7-1-97)
- 13. Home and Community-Based Waiver Recipient Limitations. The number of Medicaid recipients to

receive waiver services under the home and community based waiver for developmentally disabled recipients will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 of each new waiver year. The earliest effective date of waiver service delivery for these recipients will be October 1 of each new waiver year. (7-1-97)

144. FEDERALLY QUALIFIED HEALTH CENTER (FQHC).

Federally qualified health centers are defined as community health centers, migrant health centers or providers of care for the homeless, as well as clinics that qualify but are not actually receiving grant funds according to Sections 329, 330 or 340 of the Public Health Service Act that may provide ambulatory services to MA recipients. (4-1-90)

01. Care and Services Provided. FQHC services are defined as follows: (4-1-90)
 - a. Physician services; or (4-1-90)
 - b. Services and supplies incidental to physician services including drugs and pharmaceuticals which cannot be self-administered; or (4-1-90)
 - c. Physician assistant services; or (4-1-90)
 - d. Nurse practitioner services; or (4-1-90)
 - e. Clinical psychologist services; or (4-1-90)
 - f. Clinical social worker services; or (4-1-90)
 - g. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist or clinical social worker services which would otherwise be covered if furnished by or incident to physician services; or (4-1-90)
 - h. In the case of an FQHC that is located in an area that has a shortage of home health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home bound individual; and (4-1-90)
 - i. Other payable Title XIX payable ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide; and (4-1-90)
 - j. Pneumococcal or immunization vaccine and its administration. (4-1-90)
02. Encounter. An encounter is a face-to-face contact for the provision of medical services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist or other specialized nurse practitioner specified in Subsections 144.01.a. through 144.01.h. (12-31-91)
 - a. Contact with more than one (1) health professional or multiple contacts with the same professional in the same day and in the same location constitutes a single encounter unless the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment; (4-1-90)
 - i. A core service ordered by a physician who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter; (4-1-90)
 - ii. Multiple contacts with clinic staff of another discipline defined in Subsections 144.01.a. through 144.01.h. considered a single encounter. (12-31-91)
 - b. Other ambulatory services, not counted as an encounter or reimbursed under an encounter rate, which a FQHC may use its employees or may subcontract, includes radiology, physical therapy, occupational therapy, speech therapy, audiology services, dental services, pharmacy services, independent laboratory services, physician specialists, optometry, nutritional education or dietary counseling and monitoring by a registered dietician,

ambulance and other medical services which are rendered safely, efficiently and effectively. (4-1-90)

03. Conditions of Participation. A qualified FQHC may be recognized as a Medicaid provider as of April 1, 1990, with the following stipulations: (7-1-94)

- a. The provider is confirmed eligible by the Public Health Service on and after April 1, 1990; and (4-1-90)
- b. The applicant's request for a retroactive provider agreement may be approved from: (4-1-90)
 - i. The date on which it was granted FQHC eligibility by the Public Health Service; or (4-1-90)
 - ii. Retroactively for dates of service on or after April 1, 1990, for Medicaid provider agreements executed by October 31, 1991; or (4-1-90)
 - iii. As otherwise specified in the provider agreement for applications received after October 31, 1991. (4-1-90)
- c. The FQHC applicant shall simultaneously terminate its Medicaid rural health clinic and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement; and (4-1-90)
- d. Written agreements between the provider and subcontractors shall state that the subcontractor shall retain related records for at least three (3) years after each provider's fiscal year end. The written agreements shall assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services or their respective designee. The agreement shall specify that failure to maintain such records voids the agreement between the subcontractor and the provider. (4-1-90)

145. RURAL HEALTH CLINICS.

01. Care and Services Provided. The following items of care and services will be available to MA recipients: (11-10-81)

- a. Services furnished by a physician within the scope of practice of the medical profession under state law; and (11-10-81)
- b. Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner, a clinical psychologist or by a clinical social worker within the scope of practice of his profession under state law; and (4-1-90)
- c. Supplies that are furnished incidental to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner clinical psychologist or a clinical social worker; and (4-1-90)
- d. Part-time or intermittent visiting nurse care and related medical supplies will be provided to homebound recipients in a home health agency shortage area; and (11-10-81)
- e. Other ambulatory services furnished by a rural health clinic. (11-10-81)

02. Payment Rates. (11-10-81)

- a. Payment for rural health clinic services must not exceed the cost rate basis as established by the Medicare contractor. (11-10-81)
- b. Payment for ambulatory services must be at the rates established by the Department but must not exceed Medicare rates. (11-10-81)

146. PERSONAL CARE SERVICES.

Pursuant to Sections 39-5601 through 39-5607, Idaho Code, it is the intention of the Department to provide personal care services to eligible recipients in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. For a recipient to be eligible for personal care services, the Department must find that the recipient requires personal care services due to a medical condition which impairs their physical or mental function or independence and must find the recipient capable of being maintained safely and effectively in their own home or residence with personal care services. (1-1-91)

01. Care and Services Provided. (1-1-91)

a. Medically oriented tasks having to do with a patient's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the patient's home. Such services may include, but are not limited to: (1-1-91)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care, but excluding the irrigation or suctioning of any body cavities which require sterile procedures and the application of dressings, involving prescription, medication, and aseptic techniques; and (1-1-91)

ii. Assistance with bladder or bowel requirements which may include helping the patient to and from the bathroom or assisting the patient with bedpan routines, but excluding insertion or sterile irrigation of catheters; and (5-1-87)

iii. Assisting the patient with medications which are ordinarily self-administered, when ordered by a physician, but excluding the giving of injections or fluids into the veins, muscles, or skin, or administering of medicine; and (7-15-83)

iv. Assistance with food, nutrition, and diet activities to include the preparation of meals if incidental to medical need, as determined by a physician; and (7-15-83)

v. The continuation of active treatment training programs in the home setting to increase or maintain client independence for the developmentally disabled client. (5-1-87)

vi. Non-nasogastric gastrostomy tube feedings may be performed if authorized prior to implementation by the Department's Regional Medicaid Unit and if the following requirements are met: (2-19-92)

(1) The task is non-complex and can be safely performed in the given patient care situation; and (2-19-92)

(2) A registered nurse has assessed the patient's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, which is individualized for the patient's characteristics and needs; and (2-19-92)

(3) Persons to whom the procedure can be delegated are identified by name. The registered nurse must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing strengths and weaknesses of the person performing the procedure, and evaluate the performance of the procedure at least monthly; and (2-19-92)

(4) Any change in the patient's status or problem relative to the procedure must be reported immediately to the registered nurse; and (2-19-92)

(5) The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN, and must be readily available for review, preferably with the patient's record. (2-19-92)

(6) Medication previously received could be given by the personal care provider through the non-nasogastric tube unless contraindicated. (2-19-92)

vii. In addition to performing at least one (1) of the services listed in Subsections 146.01.a.i. through 146.01.a.vi., the provider may also perform the following services: (2-19-92)

(1) Such incidental housekeeping services essential to a patient's comfort and health, to include the changing of bed linens, rearranging furniture to enable the patient to move about more easily, laundry and room cleaning when incidental to the patient's treatment. Excluded are cleaning and laundry for any other occupant of the patient's residence; and (2-19-92)

(2) Accompanying the patient to clinics, physician office visits, or other trips which are reasonable for the purpose of obtaining medical diagnosis or treatment; and (7-15-83)

(3) Shopping for groceries or other household items required specifically for the health and maintenance of the patient. (2-19-92)

b. Service Limitations. The maximum amount of personal care services available to an eligible recipient is dependent on whether services are obtained under the Home and Community-based Services waiver (HCBS waiver) or under the State Medicaid Plan Service option. (1-1-91)

i. For adults receiving services under the State Medicaid Plan option, service delivery is limited to a maximum of sixteen (16) hours per week per recipient. (10-1-94)

ii. For individuals under the age of twenty-one (21) who meet medical necessity criteria under EPSDT, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery under the State Plan option. (10-1-94)

iii. For individuals receiving services under the HCBS waiver, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery, based on the medical need for such service as documented in the plan of care and the cost effectiveness criteria under the waiver program. (1-30-94)

02. Place of Service Delivery. Personal Care Services (PCS) may be provided only in a recipient's personal residence. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (1-1-91)

a. Certified nursing facilities (NF) or hospitals; and (1-1-91)

b. Licensed Intermediate Care Facility for the Mentally Retarded; and (7-15-83)

c. Licensed Residential Care Facility. (1-1-91)

d. Licensed child foster care Level III professional child's foster homes and adult foster homes. (1-1-91)

03. Services Delivered Following a Written Plan. (7-15-83)

a. All PCS are provided based on a written plan of care which is the responsibility of the supervisory nurse to prepare and is based on: (7-15-83)

i. The physician's information including the physician's orders; and (7-15-83)

ii. The nurse's assessment and observations of the patient; and (7-15-83)

iii. Information elicited from the recipient. (7-15-83)

b. The plan of care must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services. (7-15-83)

c. The plan of care will be signed and approved by the physician prior to the initiation of the services by the PCS provider. (7-15-83)

d. The plan must be revised and updated based upon treatment results or a patient's changing profile of needs as necessary, but at least annually. (7-15-83)

04. Physician Supervision of the Service. All Personal Care Services are provided under the order of a licensed physician. The physician must: (1-1-91)

a. Provide such medical information to the Department's Regional Medicaid Unit (RMU) as is necessary to establish that the recipient is medically eligible for NF or ICF/MR placement for those recipients receiving PCS under the Department's Home and Community Based Services waivers. For recipients eligible for PCS under the Idaho State Plan, the physician will certify, in writing, that the services are medically necessary. (7-1-94)

b. Order all services delivered by the PCS provider. Such orders are signed and dated by the physician and include, at a minimum, his signature and date of approval on the recipient's plan of care. (7-15-83)

c. Update the plan of care, including his signature and date of approval, as necessary, but at least annually. (1-1-91)

d. Recommend institutional placement of the recipient if he identifies that PCS, in combination with other community resources, are no longer sufficient to ensure the health or safety of the recipient. (1-1-91)

05. Service Supervision. (1-1-91)

a. A registered nurse who is not functioning as the personal care provider will oversee the delivery of PCS. Such oversight will include: (1-1-91)

i. In conjunction with the attending physician the development of a plan of care for the recipient; and (1-1-91)

ii. Review of the treatment given by the personal care provider through a review of the recipient's PCS record as maintained by the provider and on-site interviews with the patient at least every ninety (90) days; and (1-1-91)

iii. Reevaluate the plan of care as necessary and obtaining physician approval on all changes. The entire plan is reviewed at least annually; and (1-1-91)

iv. Immediately notifies the physician of any significant changes in the recipient's physical condition or response to the service delivery; and (1-1-91)

v. Provides an on-site visit to the recipient to evaluate changes of condition when requested by the PCS provider, QMRP supervisor, provider agency, case manager, or recipient. (1-1-91)

b. In addition to the supervisory visit by the registered nurse, all clients who are developmentally disabled, other than those with only a physical disability, as determined by the Regional Medicaid Unit will receive oversight of service delivery by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. Such oversight will include: (8-5-91)

i. In conjunction with the attending physician and supervisory RN, the QMRP will assist in the development of the plan of care for the recipient for those aspects of active treatment which are provided in the home by the PCS attendant. (1-1-91)

ii. Review of the care and/or training given by the personal care provider through a review of the recipient's PCS record as maintained by the provider, and on-site interviews with the client at least every ninety (90) days. (1-1-91)

- iii. Reevaluation of the plan of care as necessary, but at least annually. (1-1-91)
- iv. An on-site visit to the recipient to evaluate any change of condition when requested by the PCS provider, provider agency, nurse supervisor, case manager, or recipient. (1-1-91)
- 06. PCS Provider Qualifications. (1-1-91)
 - a. Persons providing PCS: Individuals may provide PCS either as PCS agency employees or as independent providers if they have at least one (1) of the following qualifications: (1-1-91)
 - i. Registered Nurse, RN: A person currently licensed by the Idaho State Board of Nursing as a registered nurse; or (7-15-83)
 - ii. Licensed Practical Nurse, L.P.N.: A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-15-83)
 - iii. Nursing Assistant: All nursing assistants who provide PCS to eligible individuals must appear on the Idaho State Board of Nursing's registry of certificated nurse aides (CNA). An individual who has completed a certified nurse aide training program may be granted provisional provider status for up to ninety (90) days by the Department to allow for the completion of competency testing and registry. (1-30-94)
 - b. All persons who care for developmentally disabled clients other than those with only physical disabilities as identified by the Department's RMU will, in addition to the completion of the requirements of Subsection 146.06.a.iii., have completed one (1) of the Department approved developmental disabilities training courses. Providers who are qualified as QMRPs will be exempted from the Department approved developmental disabilities training course. Each region may grant temporary approval to an individual who meets all qualifications except for the required developmental disabilities training course to become a PCS provider to a developmentally disabled recipient if all of the following conditions are met: (7-1-94)
 - i. The RMU has verified that there are no qualified providers reasonably available to provide services to client requesting services; and (7-1-94)
 - ii. The provider must be enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary status; and (7-1-94)
 - iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (7-1-94)
 - c. Agency providers must submit to the Department documentation of their worker's compensation and professional liability insurance coverage. In the case of worker's compensation, agencies will direct their sureties to provide a certificate of insurance to the Department. Independent providers must submit to the Department documentation of their professional liability insurance coverage. Termination of either type of insurance by the provider will be cause for termination of PCS Provider status by the Department. Agency providers will keep copies of employee health screens in their files for review by the Department as necessary. Independent providers will submit the completed health screen to the Department. Agency and independent providers will complete a criminal history check conducted by the Department. If no criminal history is indicated on the Self-Declaration form, individuals may be authorized by the Region to provide services on a provisional basis while awaiting the results of the fingerprinting process. Such authorization may be provided after the client's safety is assured by the responsible Region. (1-30-94)
 - d. Individuals providing supervision to PCS attendants. (1-1-91)
 - i. RN supervisors will have a current Idaho professional nursing license (RN). (1-1-91)
 - ii. Qualified Mental Retardation Professional (QMRP) supervisors will be qualified by education and training as required in 42 CFR 483.430. (1-1-91)

- iii. Supervising RNs and QMRPs who are independent providers will be independent contractors and obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire, maintain professional liability insurance, and report all income to the appropriate authorities, pay social security and all other state and federal taxes. (1-1-91)
- e. Provider agency. An entity which has a signed provider agreement with the Department and is capable of and responsible for all of the following: (1-1-91)
 - i. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal care attendants and the assurance of quality service provided by the personal care attendants; and (1-1-91)
 - ii. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; and (8-5-91)
 - iii. Maintenance of liability insurance coverage; and (1-1-91)
 - iv. Provision of a licensed professional nurse (RN) and, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a recipient's care; and (1-1-91)
 - v. Assignment of a qualified personal care attendant(s) to eligible recipients after consultation with and approval of such recipients; and (1-1-91)
 - vi. Assure that all PCS attendants meet the qualifications in Subsection 146.06.a.; and (12-31-91)
 - vii. Billing Medicaid for services approved and authorized by the RMU; and (1-1-91)
 - viii. Make referrals for PCS eligible recipients for case management services when a need for such services is identified; and (1-1-91)
 - ix. Conduct such criminal background checks and health screens on new and existing employees as required in Subsection 146.10 and 146.11. (12-31-91)
- f. Independent providers. Persons who meet the training requirements in Subsection 146.06.a. and will: (12-31-91)
 - i. Obtain the required training, certifications, agreements, knowledge and information needed to function as an independent provider; and (1-1-91)
 - ii. Obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire; and (1-1-91)
 - iii. Maintain professional liability insurance effective April 15, 1991, for certified nurse's aides, and upon completion of the certified nurse's aide course for all other providers; and (7-1-94)
 - iv. Report all income to the appropriate authorities, pay social security and all other state and federal taxes as an independent contractor; and (1-1-91)
 - v. Submit claims to the Medicaid Program for approved services; and (1-1-91)
 - vi. Provide for care by a fully trained and qualified replacement when unable to provide service; and (1-1-91)
 - vii. Provide unanticipated services that are not part of the plan of care in emergency situations; and (1-1-91)
 - viii. Participate in the background check and obtain the health screen required in Subsections 146.10 and 146.11; and (12-31-91)

ix. When care is provided in the provider's home, acquire the appropriate level of foster care licensure or certification. The provider must be licensed as a Level I or Level II children's foster home as defined in Section 39-1209, Idaho Code, for care of individuals under eighteen (18) years of age. For care of individuals eighteen (18) years of age or older, the provider must meet the environmental sanitation standards, fire and life safety standards, and building, construction and physical home standards for certification as an Adult Foster Home. Noncompliance with the above standards will be cause for termination of the provider's provider agreement. (10-1-94)

g. Utilization of independent providers. Independent providers will be utilized in the following circumstances: (8-5-91)

i. When a provider agency is unavailable; or (8-5-91)

ii. When, based on an assessment involving the recipient, the recipient's family and the Department's regional Medicaid staff, it is determined that an independent provider will best meet the needs of the recipient. The assessment shall include consideration of the recipient's and/or family member's ability to select a provider and manage and evaluate the care he receives. (8-5-91)

iii. Recipients receiving PCS from an independent provider should be evaluated for the need for targeted case management from a provider agency or administrative case management from the Department. (1-1-91)

iv. The independent provider will not be considered an employee of the state, recipient, or RN supervisor, but will be considered an independent contractor. (1-1-91)

h. A PCS provider cannot be a relative of any recipient to whom the provider is supplying services. (5-1-87)

i. For the purposes of this subsection, a relative is defined as a spouse or a parent of a minor child. (1-1-91)

ii. Nothing in this subsection shall be construed to prohibit a relative from providing PCS where Medicaid is not the payment source for such services. (1-1-91)

07. Recipient Eligibility Determination. An eligible recipient may qualify for PCS coverage either under the Idaho State Medicaid Plan or the Department's Home and Community Based Services waiver. For both programs, the recipient must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Eligibility for the Aged, Blind and Disabled (AABD)." The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver recipients must meet the following requirements: (12-31-91)

a. The Department's Regional Medicaid Unit must determine that: (1-1-91)

i. The recipient would qualify for nursing facility level of care as set forth in Subsections 180.03 and 180.08 if PCS were not made available; and (7-1-95)

ii. In the assessment of the RMU the patient could be maintained in their own home or residence and receive safe and effective services through the Personal Care Service Program; and (1-1-91)

iii. In the assessment of the RMU, the average monthly Medicaid cost of providing Personal Care Services and other community services to the patient would not exceed the average Medicaid cost of nursing facility care as described below: (7-1-94)

(1) The average monthly Medicaid cost of personal care and other medical services paid by Medicaid will be calculated utilizing the number of visits or hours or days of PCS and medical services prescribed by the attending physician for the patient. (1-1-91)

(2) The average monthly Medicaid patient cost of nursing facility care will be calculated by the Bureau

of Medicaid Policy and Reimbursement utilizing projected Medicaid Program expenditures for institutional care, based on the average interim rate for that type of care. (7-1-95)

(3) If the amount identified in Subsection 146.07.a.iii.(1) is less than the amount identified in Subsection 146.07.a.iii.(2) then the individual is eligible for PCS. (1-30-94)

(4) If the amount identified in Subsection 146.07.a.iii.(1) is greater than or equal to the amount identified in Subsection 146.07.a.iii.(2) then the individual is not eligible for PCS. (12-31-91)

(5) Eligible recipients receiving PCS under the Idaho State Plan must have medical justification, physician's orders, and plan of care for such services. All services will be authorized by the RMU prior to payment for the amount and duration of services. (1-1-91)

iv. Following the approval by the RMU for services under the waiver, the recipient must receive and continue to receive a waiver service. For the purposes of these rules, a waiver service is defined as personal care services in excess of sixteen (16) hours per week. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (1-1-91)

b. A recipient who is determined by the Department to be eligible for the Personal Care Services Program under the Home and Community Based Services waiver may elect not to utilize PCS, but may choose admission to a nursing facility. (7-1-94)

c. The recipient's eligibility examiner will process the application in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to a nursing facility, except that the eligibility examiner will forward potentially eligible applications immediately to the RMU for review together with the physician's prescription for Personal Care Services. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (12-31-91)

d. The decisions of the RMU regarding the acceptance of the recipients into the PCS program will be transmitted to the eligibility examiner. The eligibility examiner will notify the applicant of the Department's determination in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," except: (10-1-94)

i. The referring physician will be notified, in addition to the applicant, of the determination; and (7-15-83)

ii. If the application is approved, the RMU will provide a list of personal care providers to the client, or their representatives, to select the provider of their choice. (1-30-94)

08. Case Redetermination. (12-31-91)

a. Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 01, "Rules Governing Medicaid for Families and Children," and IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the RMU, or sooner at the request of the patient, the eligibility examiner, PCS provider agency, independent personal care provider, the supervising registered nurse, or the physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. (1-30-94)

b. The redetermination process will assess the following factors: (7-15-83)

i. The recipient's continued need for the Personal Care Services Program; and (7-15-83)

ii. Discharge from the Personal Care Services Program; and (7-15-83)

iii. Referral of the patient from the Personal Care Services Program to a nursing facility or licensed

residential care facility.

(7-1-94)

09. Criminal History Check. All personal care providers (case managers, RN supervisors, QMRP supervisors and personal care attendants) shall participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check will be conducted in accordance with IDAPA 16, Title 05, Chapter 06, "Rules Governing Mandatory Criminal History Checks."
(10-1-94)

10. Health Screen. The Department will require that a health questionnaire be completed by each independent provider and provider agency employee who serves as a personal care attendant. Provider agencies will retain this in their personnel file. Independent providers will complete the questionnaires as part of the application. If the applicant indicates on the questionnaire that he has a medical problem, the individual will be required to submit a statement from a physician that his medical condition would not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health screen is cause for termination of provider status for independent PCS providers or termination of employment for agency employees.
(1-1-91)

11. PCS Record. Three (3) types of record information will be maintained on all recipients receiving PCS and are considered to be the PCS record.
(1-1-91)

a. Personal Care Provider Information. Each provider will maintain a written documentation of each visit made to a patient, and will record at a minimum the following information:
(1-1-91)

i. Date and time of visit; and
(1-1-91)

ii. Services provided during the visit; and
(1-1-91)

iii. A statement of the recipient's response to the service, including any changes noted in the recipient's condition; and
(1-1-91)

iv. Length of visit and unless it is determined by the RMU that the recipient is unable to do so, the record of service delivery should be verified by the recipient as evidenced by their signature on the service record; and
(1-1-91)

v. Any changes in the treatment plan authorized by the referring physician or supervising registered nurse as the result of changes in the recipient's condition.
(1-1-91)

vi. A copy of the information contained in Subsections 146.13.a.i. through 146.13.a.v., will be maintained in the recipient's home unless authorized to be kept elsewhere by the RMU. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services.
(1-1-91)

b. Plan of Care. The plan of care which is initiated by the attending physician, developed by the supervising RN and, when appropriate, QMRP must specify diagnosis, general treatment and the Personal Care Services which are required by the recipient. The plan will contain all elements required by Subsection 146.03 and a copy of the most current plan of care will be maintained in the recipient's home and will be available to the PCS Attendant, Supervising RN, QMRP and, if applicable, the case manager.
(12-31-91)

c. Oversight Information. In addition to the plan of care, at least every ninety (90) days the Supervising RN and, where required, the QMRP will verify, in writing, that the services provided were consistent with the treatment plan. Any changes in the treatment plan will be documented and include the signature of the Supervising RN or QMRP.
(10-1-94)

12. Provider Responsibility for Notification. It is the responsibility of the PCS provider to notify either the supervising RN or physician when any significant changes in the recipient's condition are noted during service delivery. Such notification will be documented in the PCS record.
(7-15-83)

13. Records Maintenance. In order to provide continuity of services, when a patient is transferred among independent providers, or when the independent provider changes Supervising RNs, all of the foregoing patient's records will be delivered to and held by the field office of the Department until a replacement provider or

Supervising RN assumes the case. When a patient utilizing independent PCS providers leaves the Personal Care Services Program, the records will be retained by the Department as part of the patient's closed case record. Provider agencies will be responsible to retain their clients' records for three (3) years following the date of service. (10-1-94)

14. Provider Coverage Limitations. Each individual person who is an independent PCS provider may not receive compensation from Medicaid funds for service to more than three (3) PCS recipients on any given day except: (1-1-91)

a. Where three (3) or more recipients live within the same building, in which case the maximum number of recipients for which a PCS provider may be compensated shall be five (5); or (7-15-83)

b. If the recipient's residence is the home of the PCS provider, no more than two (2) clients may be served. (1-1-91)

c. As approved by the Director or his designee. (7-15-83)

15. Home and Community-Based Waiver Recipient Limitations. The number of unduplicated count Medicaid recipients to receive personal care services under the home and community-based waiver will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for personal care services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 of each new waiver year. The earliest effective date of personal care services service delivery for these clients will be October 1 of each new waiver year. (10-1-94)

16. Community Awareness Program. The Department will establish a community awareness program that will educate Idaho citizens regarding the purpose and function of all long-term care alternatives including, but not limited to, personal care services and individual recipient rights. This program will be developed in cooperation with other state agencies including, but not limited to, the Office On Aging and the Division of Vocational Rehabilitation. (1-1-91)

147. TARGETED CASE MANAGEMENT FOR PERSONAL CARE SERVICE RECIPIENTS.

The Department will purchase case management (CM) services for Medicaid-eligible recipients who have been approved for personal care services (PCS). Services will be provided by an organized case management provider agency who has entered into a written provider agreement with the Department. Services will be authorized in amount, scope and duration by regional Medicaid unit (RMU) staff. (10-28-90)

01. Eligible Target Group. Those recipients who are approved for PCS and who require and desire assistance to adequately access services necessary to maintain their own independence in the community are eligible for case management services. The scope and amount of services will be determined by the Regional Medicaid Unit based upon the individual community service plan. (10-28-90)

02. Service Definition. For the purposes of providing case management services to PCS eligible recipients, case management is an individualized service provided by an employee of a qualified case management provider agency acting in the role of a coordinator of multiple services to ensure that the various needs of the individual are assessed and met. Components of case management are: (10-28-90)

a. An assessment of the service needs of the client including information available regarding the client and a face-to-face interview with the client and significant others; and (10-28-90)

b. The development of an individual community service plan; and (10-28-90)

c. Arranging for and assisting with access to all services necessary to maintain the recipient in the community at the highest level of independence possible; and (10-28-90)

d. Face-to-face contact at least every thirty (30) days with the recipient and others as necessary to coordinate and monitor the progress of the existing individual community service plan. (10-28-90)

03. Core Services. The core services consist of the following: (10-28-90)

- a. Assessment. A comprehensive evaluation of the recipient's ability to function in the community including, but not limited to: (10-28-90)
- i. Medical needs, physical problems and strengths; and (10-28-90)
 - ii. Mental and emotional problems and strengths; and (10-28-90)
 - iii. Physical living environment; and (10-28-90)
 - iv. Vocational and educational needs; and (10-28-90)
 - v. Financial and social needs; and (10-28-90)
 - vi. An evaluation of the community support system including the involvement of family or significant others; and (10-28-90)
 - vii. Safety and risk factors; and (10-28-90)
 - viii. Legal status. (10-28-90)
- b. Individual community service plan (ICSP) development. Based on the information obtained during the recipient assessment and input obtained from professionals involved with the recipient, the case manager will develop a written plan which will include at least the following: (10-28-90)
- i. Problems identified during the assessment; and (10-28-90)
 - ii. Overall goals to be achieved; and (10-28-90)
 - iii. Reference to all services and contributions provided by the informal support system including the actions, if any, taken by the CM to develop the support system; and (10-28-90)
 - iv. Documentation of who has been involved in the service planning, including the client's involvement; and (10-28-90)
 - v. Schedules for CM monitoring and reassessment; and (10-28-90)
 - vi. Documentation of unmet need and service gaps; and (10-28-90)
 - vii. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery. (10-28-90)
 - viii. The ICSP will be reevaluated and updated by the case manager at least annually and approval continued, if appropriate, by the Regional Medical Unit. (10-22-93)
 - ix. A copy of the current ICSP will be provided to the recipient or their legal representative. (10-28-90)
- c. Linking/coordination of service. The case manager will actively advocate for services required by the client and coordinate such service delivery between multiple agencies, individuals and others. (10-28-90)
- d. Continuity of care. The case manager will monitor and evaluate the services required and received by the recipient at least every thirty (30) days and is responsible to assure that the services are delivered in accordance with the individual community service plan. If new needs are identified, then the individual community service plan will be revised and the new needs addressed. (10-28-90)
- e. The case manager will encourage the independence of the recipient by demonstrating to the

individual how to best access service delivery systems such as energy assistance, legal assistance, financial assistance, etc. Such encouragement will be conducted on an ongoing basis. (10-22-93)

04. Record Requirements. In addition to the development and maintenance of the individual community service plan, the following documentation must be maintained by the case management provider: (10-28-90)

- a. Name of recipient; and (10-28-90)
- b. Name of provider agency and person providing the service; and (10-28-90)
- c. Date and time of service; and (10-28-90)
- d. Place of service; and (10-28-90)
- e. Activity record describing the recipient and community contact; and (10-28-90)
- f. Signature of the recipient on the ICSP; and (10-28-90)
- g. Written consent and acceptance of case management services and release of information forms. (10-28-90)

05. Case Manager Provider Qualifications/Limitations. All individual case managers must be employees of an organized entity that has a valid provider agreement with the Department's Bureau of Medicaid Policy and Reimbursement (10-22-93)

a. The case management agency cannot provide personal care services and case management services to the same recipient. (10-28-90)

b. The employing entity will supervise individual case management providers and assure that the following qualifications are met. (10-28-90)

i. The individual case manager must be a licensed social worker; or licensed professional nurse (R.N.); or have at least a BA or BS in a human services field and at least one (1) year's experience in service delivery to the service population. (10-22-93)

ii. The individual case manager must be supervised by an individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse/RN) with at least two (2) years experience in service delivery to the service population. The supervisor will oversee the service delivery and have the authority and responsibility to remove the individual CM if the client's needs are not met. (10-28-90)

iii. Individual case managers will not be assigned case management responsibility for more than thirty (30) active CM clients. (10-28-90)

iv. The Bureau may grant a waiver of the caseload limit when requested by the agency when the following criteria are met: (10-22-93)

(1) The availability of case management providers is not sufficient to meet the needs of the service area. (10-22-93)

(2) The recipient that has chosen the particular provider that has reached their limit, has just cause to need that particular manager over other available managers. (10-22-93)

(3) The individual case manager's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of CM service) clients. (10-22-93)

- v. The request for waiver must include: (10-22-93)
 - (1) The time period for which the waiver is requested; and (10-22-93)
 - (2) The alternative caseload limit requested; and (10-22-93)
 - (3) Documentation that the granting of the waiver would not diminish the effectiveness of the case manager's services, violate the purposes of the program, or adversely affect the health and welfare of any of the case managers' clients. (10-22-93)
- vi. The Bureau may impose any conditions, including limiting the duration of a waiver, which it deems necessary to ensure the quality of case management services provided. (10-22-93)
- 06. CM Agency Responsibilities. The CM agency must demonstrate prior to approval of provider status by the Department: (10-28-90)
 - a. The capacity to provide all case services as required in Subsection 147.03; and (12-31-91)
 - b. Experience with the target population. If a limited segment of the population will be served, such specialization must be indicated; and (10-28-90)
 - c. Appropriate personnel practices including, but not limited to: (10-28-90)
 - i. Conduct an orientation program for all new employees which covers at least the local resources available, case management service delivery, confidentiality of information and client rights. (10-28-90)
 - ii. Sufficient staff to meet the CM service needs of the target population; and (10-28-90)
 - iii. Provider screening and hiring practices which assure provider qualifications in accordance with Subsection 147.05; and (12-31-91)
 - iv. Qualified supervision of individual CM staff; and (10-28-90)
 - v. An administration system which will assume adequate documentation of cases and services. (10-28-90)
- 07. Recipient's Choice. The eligible recipient will have free choice of case management providers as well as the providers of medical and other services under the case management program. (10-28-90)
- 08. Payment for Services. The scope, duration and total hours of case management services to be reimbursed by the Medicaid Program will be authorized by the Department's regional Medicaid program staff. (10-28-90)
 - a. Payment for case management services will not duplicate payment made by any other private or public reimbursement source to the provider for the same purpose. (10-28-90)
 - b. The initial evaluation and ICSP development will be authorized by the RMU and paid using a fee-for-service established by the Department's Bureau of Medicaid Policy and Reimbursement. The RMU may also authorize up to eight (8) hours of service delivery at the time that the evaluation and care plan is authorized. (10-28-90)
 - c. Ongoing CM services will be authorized by the RMU and paid utilizing an hourly rate for service delivery. The amount to be paid will be established by the Department's Bureau of Medicaid Policy and Reimbursement. This rate will include travel costs. (10-28-90)
 - d. Medicaid program reimbursement for CM services is limited to eight (8) hours of service delivery per client per month. Additional hours may be authorized in writing by the RMU based on documentation of client

need by the provider or client. (10-28-90)

e. Failure to provide services for which reimbursement has been received or to maintain records as required in Subsection 147.04 will be cause for recoupment of payments for the services. (12-31-91)

f. Individuals requiring and desiring case management services will be identified by the regional Medicaid program personnel during the approval process for personal care services based on referrals from individual supervising nurses and/or PCS provider agencies. Individuals will be identified based on their medical, social and family situation. The scope, duration and total hours of case management services to be provided will be based upon the needs as determined in the ICSP. Case management services will not be provided to individuals who choose to direct and obtain their own services within the community. (10-28-90)

g. Individuals who are identified by the RMU as not meeting the criteria for inclusion in the target population and are therefore not eligible for CM services may appeal such action utilizing procedures contained in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings." (7-1-94)

148. PROVIDER REIMBURSEMENT FOR PERSONAL CARE SERVICES.

01. Reimbursement Rate. Personal care providers will be paid a uniform reimbursement rate for service as established by the Department pursuant to Section 39-5606, Idaho Code, on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (1-1-91)

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 nonmedical client transportation or provider transportation to and from the recipient's home. Fees will be calculated as follows: (1-1-91)

a. Annually the Bureau of Medicaid Policy and Reimbursement will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, and Nurse's aide) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year. (1-30-94)

b. The Bureau of Medicaid Policy and Reimbursement will then establish three (3) payment levels for both provider agencies and independent providers for PCS attendant services as follows: (1-30-94)

i. Weekly service needs of zero to sixteen (0-16) hours or waiver recipients zero to eight (0-8) hours/day:

Provider Agencies	WAHR x 1.55	=	\$ amount/hour
Independent Providers	WAHR x 1.22 (which is a supplemental component to cover training, social security and liability insurance)	=	\$ amount/hour

(1-30-94)

ii. Extended visit, one (1) recipient (eight and one-quarter hour (8.25) up to twenty-four (24) hours):

Provider Agencies	(WAHR x actual hours of care up to 5 hours x 1.55) plus (\$.65 x 1.55 hours on site on-call)	=	\$ amount (Maximum \$53.33)
Independent Providers	(WAHR x actual hours of care up to 5 hours x 1.22) plus (\$.65 x 1.22 x actual hours on site on-call)	=	\$ amount (Maximum \$50.57)

(7-1-97)

- iii. Extended visit, two (2) recipients (six and one-quarter (6.25) up to twenty-four (24) hours):

Provider Agencies	(WAHR x actual hours of care up to 4 hours) x (1.55 plus \$.65 x 1.55 x hours on site on-call)	=	\$ amount (Maximum \$45.46)
Independent Providers	(WAHR x hours actual care up to 4 hours x 1.22) plus (\$.65 x 1.22 x hours on site on-call)	=	\$ amount (Maximum \$37.14)

(7-1-97)

c. The attending physician will be reimbursed for services provided using current payment levels and methodologies for other physician services provided to eligible recipients. (1-1-91)

d. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Client evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMU. (1-1-91)

i. The number of supervisory visits by the RN and QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMU. (1-1-91)

ii. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMU. (1-1-91)

149. CLIENT PARTICIPATION IN THE COST OF WAIVER SERVICES.

A recipient will not be required to participate in the cost of waiver services unless the recipient's entitlement to MA is based on approval for, and receipt of, a waiver service and income limitations contained in IDAPA 16.03.05.634. Income excluded under the provisions of IDAPA 16.03.05.613 and 615 is excluded in determining client participation. (7-1-97)

01. Base Participation. Base participation is income available for client participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 149.04. Base participation is calculated by the recipient's Eligibility Examiner. The incurred medical expense deduction is calculated by the RMU or ACCESS unit. (7-1-97)

02. Community Spouse. Base participation for a recipient with a community spouse is calculated under IDAPA 16.03.05.615. A community spouse is the spouse of an HCBS recipient who is not an HCBS recipient and is not institutionalized. (7-1-97)

03. No Community Spouse. Base participation for a recipient with no community spouse is calculated under IDAPA 16.03.05.613, using the appropriate HCBS personal needs allowance. The HCBS personal needs allowance is equal to the AABD allowances for a recipient living alone in his own home. The HCBS personal needs allowance for a recipient living in room and board, or in an adult foster care home at the recipient's level of care, is equal to the AABD allowances for a recipient in room and board, or in an adult foster care home at that level of care. These allowances are specified in IDAPA 16.03.05.407, 408, and 410. The HCBS personal needs allowance for the clients receiving Waiver Services for Adult Developmentally Disabled Recipients is three (3) times the federal SSI benefit amount to an individual in his own home. (7-1-97)

04. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether an individual's incurred expenses for such limited services meet the criteria for deduction. The recipient must report such expenses and provide verification in order for an expense to be considered for deduction. Deductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported to the Department by the recipient. (7-1-97)

05. Remainder After Calculation. Any remainder after the calculation in Subsection 149.04 is the

maximum participation to be deducted from the recipient's provider payments to offset the cost of personal care services. The participation will be collected from the recipient by the provider agency or independent provider. The provider and the recipient will be notified by the Department of the amount to be collected. (7-1-97)

06. Recalculation of Client Participation. The client participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (7-1-97)

150. TRANSPORTATION.

"Transportation" includes expenses for transportation, cost of meals and lodging en route to and from receiving medical care or treatment, and while receiving medical care or treatment. It also includes the cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging and, if the attendant is not a member of the recipient's family, salary. Review of "transportation" is required to insure that only necessary and reasonable expenses are paid. Certain transportation services require preapproval, and other services require review after the services have been rendered. An exception to preapproval can be made when the service was an emergency or when eligibility for Medicaid is determined after the service was provided, or when a retrospective approval is required by the Department. (2-12-96)T

01. Scope of Coverage and General Requirements for Transportation. (2-12-96)T

a. The Department will pay for necessary transportation for a Medicaid recipient to receive medical care or treatment from providers of Medicaid approved medical services. Out-of-state transportation will not be reimbursed without obtaining authorizations required in Subsection 015.03. Transportation services are subject to review by the Department or its designee prior to services being rendered, or on a retrospective basis. Transportation service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that a transportation service is not covered, then no Medicaid payment will be made for the transportation service. Reimbursement for transportation services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-12-96)T

b. The Department or its designee may authorize the transportation, meals, and lodging costs of an attendant or one (1) immediate family member to accompany the recipient, if necessary, and salary for the attendant, if he is not a member of the recipient's family. The Department will not pay the meals or lodging costs for of a salaried attendant once the recipient being escorted is admitted to an inpatient facility. The Department will pay the meals and lodging costs of one (1) immediate family member while the recipient is an inpatient in a facility, if deemed necessary due to the recipient's age or other factors, and authorized by the Department or its designee. (2-12-96)T

c. When lodging is required, the Department or its designee will authorize it insuring that the least expensive yet most appropriate lodging is provided. Receipts for lodging may be required by the Department. (2-12-96)T

d. For any requests for transportation costs to receive covered medical care or treatment, the Department or its designee will only authorize transportation costs to the nearest available, appropriate Medicaid provider. In some cases, a referral from the recipient's primary care physician is also required. (2-12-96)T

e. If private vehicle transportation is used, the Department will pay for such transportation at rates established by the Department. The private carrier is responsible for providing all necessary insurance at no cost to the Department. (2-12-96)T

f. If other than private vehicle transportation is used, the transportation must be the least expensive yet the most appropriate form available. The Department will make payment for such transportation at rates established by the Department. The carrier is responsible for providing all necessary insurance at no cost to the Department. (2-12-96)T

g. Reimbursement will be made by the Department for necessary transportation to any person, including but not limited to the recipient, or a relative or friend of the recipient. The Department will make payment to the recipient if the recipient has paid for or provided the transportation service, or to the actual provider of the

transportation service. Each billing invoice must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Providers must bill on a HCFA 1500 claim form. If no attachments to the claim are required, the provider may bill electronically. Payment for transportation costs will not be issued prior to the service being rendered. (2-12-96)T

h. Commercial transportation companies, such as taxi, intra-city bus or van, inter-city bus or van, intrastate bus or van, interstate bus or van, airlines, car rental agencies, or lodging facilities, must not charge Medicaid recipients more than is charged to the general public for the same service. (2-12-96)T

i. If the recipient has two (2) or more separate medical appointments in a day which necessitate separate trips by the same or a different transporter, the Department will pay for a round trip to transport the recipient to each appointment. (2-1-97)T

j. In order for the Department to pay for transportation services, the recipient must be taking the trip to actually receive medical care or treatment from a Medicaid provider. (2-1-97)T

k. The Department will not pay for transportation or lodging when those services are available and provided at no cost by organizations such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies. (2-12-96)T

02. Preauthorization for Transportation to a Distant Point. Preauthorization of transportation to a distant point, either in or out-of-state, is required. For purposes of these rules, a "distant point" is defined as more than ten (10) miles from the recipient's residence. The Department or its designee must determine the following: (2-12-96)T

a. That adequate and comparable medical services are not available locally. When the services are available locally and/or more than one (1) service provider is within the local area, the Department's reimbursement is limited to round trip mileage to the closest provider of the necessary service; and (7-1-97)

b. That an appointment for covered medical care or treatment has been made with a provider at the distant point; and (2-12-96)T

c. If applicable, that a referral has been made by the patient's attending physician. (2-12-96)T

d. Transportation will not be authorized unless out-of-state care authorizations have been obtained as required in Subsection 015.03. Exceptions to this requirement are: Veteran's Hospitals and specialty hospitals which do not make a charge to the general public. Therefore, no authorization for hospitalization is made by Medicaid. (2-15-93)

e. The Department will only authorize meals when overnight travel to a distant point is required and cooking facilities are not available. The actual cost of the meals will be authorized up to the amount set by the Department. Meals and lodging costs will not be paid if the recipient and/or the attendant stays in a private home that is not a lodging facility. (2-12-96)T

03. Scope of Coverage and General Requirements for Ambulance Services. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department or its designee. Ambulance services are subject to review by the Department or its designee prior to the service being rendered, and on a retrospective basis. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." Payment for ambulance services is subject to the following limitations: (2-12-96)T

a. If a Medicaid recipient is also a Medicare recipient, a provider must first bill Medicare for services rendered. (2-12-96)T

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure an "Explanation of Benefits" (EOB) from Medicare, attach it to the appropriate claim form and submit it to the Department. (2-12-96)T

c. For Medicare recipients, the Department will reimburse providers for deductible and co-insurance not to exceed the Medicaid allowed amount for the services billed. (2-12-96)T

d. Before payment is made by the Department, a Medicaid recipient must utilize any available insurance benefits to pay for ambulance services. (2-12-96)T

e. Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a recipient manifests acute symptoms and/or signs which, by reasonable medical judgement of the Department or its designee, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. If such condition exists, and treatment is required at the recipient's location, or transport of the recipient for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department or its designee. For purposes of reimbursement, in non emergency situations, the provider must provide justification to the Department or its designee that travel by ambulance is medically necessary due to the medical condition of the recipient, and that any other mode of travel would, by reasonable medical judgement of the Department or its designee, result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. (2-12-96)T

f. Each billing invoice for ambulance service must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Ambulance units that are not hospital- based must bill on a HCFA 1500 claim form and are reimbursed on a fee for service schedule. Hospital- based ambulance units must bill on a UB-92 claim form and are reimbursed at the hospital's outpatient reimbursement rate. If no attachments to the claim are required, the provider may bill electronically. (2-12-96)T

g. All Emergency Medical Services (EMS) Providers that provide services to Medicaid recipients in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department, and must be governed by IDAPA 16.02.03, "Rules Governing Emergency Medical Services." Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (2-1-97)T

h. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the recipient was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department or its designee. (2-12-96)T

i. Ambulance services providers cannot charge Medicaid recipients more than is charged to the general public for the same service. (2-12-96)T

04. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (2-12-96)T

a. The point of pickup is inaccessible by land vehicle; or (11-10-81)

b. Great distances or other obstacles are involved in getting the recipient to the nearest appropriate facility and speedy admission is essential; and (11-10-81)

c. Air ambulance service will be covered where the recipient's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (11-10-81)

d. Air ambulance services must be approved in advance by the Department or its designee except in

emergency situations. Emergency air ambulance services must be authorized by the Department or its designee on a retrospective basis. (2-12-96)T

e. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the recipient. (2-12-96)T

05. Ambulance Reimbursement. (2-12-96)T

a. Base rate for ambulance services includes customary patient care equipment including such items as stretcher, clean linens, reusable devices, and reusable equipment. (11-10-81)

b. Not to be included as a base rate and to be billed separately are charges for each nonreusable item and disposable supply, such as oxygen, triangular bandage and dressing, which may be required for the care of the recipient during transport. Oxygen will be reimbursed according to volume used by the recipient during transport. The volume must appear in the appropriate field on the claim. (2-12-96)T

c. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department or its designee. (2-12-96)T

d. If a physician is in attendance during transport, he is responsible for the billing of his services. (11-10-81)

e. Reimbursement for waiting time will not be considered unless documentation submitted to the Department or its designee identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (2-12-96)T

f. Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintains. At least, this level of personnel are required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the level of ambulance license the unit has been issued. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Intermediate Life Support (ILS) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Advanced Life Support (ALS) rate. In addition to the base rate, the Department will reimburse mileage. These rates are set by the Department. (2-1-97)T

g. If multiple licensed EMS providers are involved in the transport of a recipient, only the ambulance provider which actually transports the recipient will be reimbursed for the services. In situations where personnel and equipment from a licensed ALS provider boards an ILS or BLS ambulance, the transporting ambulance may bill for ALS services as authorized by the Department or its designee. In situations where personnel and equipment from a licensed ILS provider boards a BLS ambulance, the transporting ambulance may bill for ILS services as authorized by the Department or its designee. In situations where medical personnel and equipment from a medical facility are present during the transport of the recipient, the transporting ambulance may bill at the ALS level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALS, ILS, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the recipient during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department or its designee. The ground ambulance provider may also bill for their part of the trip as authorized by the Department or its designee. (2-1-97)T

h. If multiple licensed EMS providers transport a recipient for different legs of a trip, each provider must bill their base rate, mileage, and for nonreusable supplies and oxygen used, as authorized by the Department or its designee. (2-12-96)T

i. If a licensed transporting EMS provider responds to an emergency situation and treats the recipient,

but does not transport the recipient, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate and will pay for nonreusable supplies and oxygen used at the scene. This service requires authorization from the Department or its designee, usually on a retrospective basis. (2-12-96)T

j. If an ambulance vehicle and crew have returned to a base station after having transported a recipient to a facility and the recipient's physician orders the recipient to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (2-12-96)T

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the recipient is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (2-12-96)T

l. If a licensed transporting EMS provider responds to a recipient's location and upon examination and evaluation of the recipient, finds that their condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department or its designee, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the recipient has left the scene. No payment will be made for mileage, supplies or oxygen, nor will payment be made to an EMS provider who is licensed as a non-transporting provider. (2-12-96)T

151. -- 154. (RESERVED).

155. SOCIAL SERVICES.

01. In General. Each Field Office staff person is to be alert to the health needs of recipients as a part of the provision of social services. (11-10-81)

02. Information. (7-1-93)

a. Recipients must be informed by the Field Office of the amount, scope, and duration of medical care and services available through MA, and the steps necessary to secure the services. (11-10-81)

b. Medical consultation is available to the Field Office on behalf of a MA recipient through the Bureau. (11-10-81)

c. Informational and training brochures are available to the Field Office through the Bureau concerning medical problems, diagnosis and treatment, the implications of serious disabilities and illnesses, and the social services available to families and persons suffering from serious illnesses or disabilities. (11-10-81)

156. -- 159. (RESERVED).

160. LONG-TERM CARE.

01. Care and Services Provided. (1-16-80)

a. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following (see also Subsection 180.04): (7-1-94)

i. Room and board; and (1-16-80)

ii. Bed and bathroom linens; and (1-16-80)

iii. Nursing care, including special feeding if needed; and (1-16-80)

iv. Personal services; and (1-16-80)

- v. Supervision as required by the nature of the patient's illness; and (1-16-80)
 - vi. Special diets as prescribed by a patient's physician; and (1-16-80)
 - vii. All common medicine chest supplies which do not require a physician's prescription including but not limited to mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; and (1-16-80)
 - viii. Dressings; and (1-16-80)
 - ix. Administration of intravenous, subcutaneous, and/or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and (1-16-80)
 - x. Application or administration of all drugs; and (1-16-80)
 - xi. All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and rubber gloves; and (1-16-80)
 - xii. Social and recreational activities; and (1-16-80)
 - xiii. Items which are utilized by individual patients but which are reuseable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (11-10-81)
- b. Intermediate Care-Mentally Retarded. The minimum content of care and services for ICF/MR must include the services identified in Subsections 160.01.a. and Subsection 180.08, and social and recreational activities. (7-1-94)
- c. Direct Care Staff. Direct Care staff in an ICF/MR are defined as the present on-duty staff calculated over all shifts in a twenty-four (24) hour period for each defined residential living unit. Direct care staff in an ICF/MR include those employees whose primary duties include the provision of hands-on, face-to-face contact with the clients of the facility. This includes both regular and live-in/sleep-over staff. It excludes professionals such as psychologists, nurses, and others whose primary job duties are not the provision of direct care, as well as managers/ supervisors who are responsible for the supervision of staff. (5-25-93)
- d. Level of Involvement. Level of involvement relates to the severity of an MA recipient's mental retardation. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. (5-25-93)
- e. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to an MA recipient in an ICF/MR setting will be dependent upon the level of involvement and the need for services and supports of the recipient as determined by the Department, or its representative, and will be subject to the following constraints: (7-1-94)
- i. Direct care staffing for a severely and profoundly retarded recipient residing in an ICF/MR must be a maximum of sixty-eight point twenty five (68.25) hours per week. (5-25-93)
 - ii. Direct care staffing for a moderately retarded recipient residing in an ICF/MR must be limited to a maximum of fifty-four point six (54.6) hours per week. (5-25-93)
 - iii. Direct care staffing for a mildly retarded recipient residing in an ICF/MR must be limited to a maximum of thirty four point one two five (34.125) hours per week. (5-25-93)
- f. The annual sum total level of allowable direct care staff hours for each residential living unit will be determined in the aggregate as the sum total of the level of staffing allowable for each resident residing in that residential living unit as determined in Subsection 160.01.e. (5-25-93)

g. Phase-in Period. If enactment of Subsection 160.01.e. requires a facility to reduce its level of direct care staffing, a six (6) month phase-in period will be allowed from the date of the enactment of this section, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances will be the weighted average of the hourly rates paid to a facility's direct care staff, plus the associated benefits, at the end of the phase-in period. (5-25-93)

h. Exceptions. Should a provider be able to show convincing evidence documenting that the annual aggregate direct care hours as allowed under this section will compromise their ability to supply adequate care to the clients, as required by federal regulations and state rules, within an ICF/MR residential living unit and that other less costly options would not alleviate the situation, the Department will approve an additional amount of direct care hours sufficient to meet the extraordinary needs. (5-25-93)

02. Conditions of Payment. (2-25-93)

a. As a condition of payment by the Department for long-term care on behalf of MA recipients, 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. (5-25-93)

b. Nursing facilities and ICF/MR facilities will be reimbursed in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." (5-25-93)

03. Post-eligibility Treatment of Income. Where an individual is determined eligible for MA participation in the cost of his long term care, the Department must reduce its payment to the long term care facility by the amount of his income considered available to meet the cost of his care. This determination is made in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05.585, "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)." (5-25-93)

a. The amount which the MA recipient receives from SSA as reimbursement for his payment of the premium for Part B of Title XVIII (Medicare) is not considered income for patient liability (see Subsection 165.02 and Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, Subsection 522.02.c., "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD).") (5-25-93)

b. Payment by the Department for the cost of long term care is to include the date of the recipient's discharge only if the discharge occurred after 3:00 p.m. 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 shall be deemed to exist. (11-1-86)

04. Payments for Periods of Temporary Absence. Payments may be made for reserving beds in long-term care facilities for recipients during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: (10-22-93)

a. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than the larger of: (4-6-83)

i. Five (5) beds; or (4-6-83)

ii. Five percent (5%) of the total number of licensed beds in the facility. (4-6-83)

b. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for: (4-6-83)

i. Therapeutic home visits for other than ICF/MR residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days in any consecutive twelve (12) month period so long as the days are part of a treatment plan ordered by the attending physician. (12-22-88)

ii. Therapeutic home visits for ICF/MR residents of up to thirty-six (36) days in any consecutive twelve (12) month period so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the RMU must be obtained for any home visits exceeding fourteen (14) consecutive days.

(10-22-93)

c. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following:

(4-6-83)

i. Seventy-five percent (75%) of the audited allowable costs of the facility unless the facility serves only ICF/MR residents, in which case the payment will be one hundred percent (100%) of the audited allowable costs of the facility; or

(12-22-88)

ii. The rate charged to private paying patients for reserve bed days.

(4-6-83)

05. Payment Procedures. Each long term care facility must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim in behalf of a MA recipient unless the information on the claim is consistent with the information in the Department's computer eligibility file.

(11-10-81)

06. Long-Term Care Facility Responsibilities. In addition to the responsibilities set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho," each long term care facility administrator, or his authorized representative, must report:

(7-1-94)

a. The following information to the appropriate Field Office within three (3) working days of the date the facility has knowledge of:

(7-13-89)

i. Any readmission or discharge of a recipient, and any temporary absence of a recipient due to hospitalization or therapeutic home visit; and

(7-13-89)

ii. Any changes in the amount of a recipient's income; and

(1-16-80)

iii. When a recipient's account has exceeded one thousand four hundred dollars (\$1,400) for a single individual or two thousand one hundred fifty dollars (\$2,150) for a married couple; and

(11-10-81)

iv. Other information about a recipient's finances which potentially may affect eligibility for MA.

(11-10-81)

b. PASARR. All Medicaid certified nursing facilities must participate in, cooperate with, and meet all requirements imposed by, the Preadmission Screening and Additional Resident Review program (hereafter "PASARR") as set forth in 42 CFR, Part 483, Subpart C, which, pursuant to Idaho Code Section 67-5229, is incorporated by reference herein.

(10-20-96)T

i. Background and purpose. The purpose of these provisions is to comply with and implement the PASARR requirements imposed on the state by federal law. The purpose of those requirements is to prevent the placement of individuals with mental illness (MI) or mental retardation (MR) in a nursing facility (NF) unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. This is accomplished by both pre-admission screening (PAS) and additional resident review (ARR). Individuals for whom it appears that a diagnosis of MI or MR is likely are identified for further screening by means of a Level I screen. The actual PASARR is accomplished through a Level II screen where it is determined whether, because of the individual's physical and mental condition, he or she requires the level of services provided by an NF. If the individual with MI or MR is determined to require an NF level of care, it must also be determined whether the individual requires specialized services. PASARR applies to all individuals entering or residing in an NF, regardless of payment source. (10-20-96)T

ii. Policy. It is the policy of the Department that the difficulty in providing specialized services in the NF setting makes it generally inappropriate to place individuals needing specialized services in an NF. This policy is

supported by the background and development of the federal PASARR requirements, including the narrow definition of MI adopted by federal law. While recognizing that there are exceptions, it is envisioned that most individuals appropriate for NF placement will not require services in excess of those required to be provided by NFs by 42 CFR 483.45. (11-6-93)

iii. Inter-agency agreement. The state Medicaid agency will enter into a written agreement with the state mental health and mental retardation authorities as required in 42 CFR 431.621(c). This agreement will, among other things, set forth respective duties and delegation of responsibilities, and any supplemental criteria to be used in making determinations. (11-6-93)

(1) The "State Mental Health Authority" (hereafter "SMHA") is the Division of Family and Community Services of the Department, or its successor entity. (11-6-93)

(2) The "State Mental Retardation or Developmental Disabilities Authority" (hereafter "SDDA") is the Division of Family and Community Services of the Department, or its successor entity. (11-6-93)

iv. Coordination. The PASARR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and NFs. PASARR activities, to the extent possible, will be coordinated through the Regional Medicaid Units (RMUs). RMUs will also be responsible for record retention and tracking functions. However, NFs are responsible for assuring that all screens are obtained and for coordination with the RMU, independent MI evaluators, the SMHA and SDDA, and their designees. Guidelines and procedures on how to comply with these requirements can be found in "Statewide PASARR Procedures," a reference guide. (11-6-93)

(1) Level I Screens. All required Level I reviews must be completed and submitted to the RMU, prior to admission to the facility. (11-6-93)

(2) Level II Screens. When a NF identifies an individual with MI and/or MR through a Level I screen, or otherwise, the NF is responsible for contacting the SMHA or SDDA (as appropriate), or its designee, and assuring that a level II screen is completed prior to admission to the facility, or in the case of an existing resident, completed in order to continue residing in the facility. (11-6-93)

(3) Additional Resident Reviews (ARR). An individual identified with MI and/or MR must be reviewed and a new determination made promptly after a significant change in his/her physical or mental condition. The facility must notify the RMU of any such change within two (2) working days of its occurrence. For the purpose of this section, significant change for the client's mental condition means a change which may require the provision of specialized services or an increase in such services. A significant change in physical condition is a change that renders the client incapable of responding to MI or D.D. program interventions. (10-20-96)T

v. Determinations. Determinations as to the need for NF care and determinations as to the need for specialized services should not be made independently. Such determinations must often be made on an individual basis, taking into account the condition of the resident and capability of the facility to which admission is proposed to furnish the care needed. When an individual identified with MI and MR is admitted to a NF, the NF is responsible for meeting that individual's needs, except for the provision of specialized services. (7-1-94)

(1) Level of care. (11-6-93)

(a) Individual determinations. Must be based on evaluations and data as required by these rules. (11-6-93)

(b) Categorical determinations. Recognizing that individual determinations of level of care are not always necessary, those categories set forth as examples at 42 CFR 483.130(d) are hereby adopted as appropriate for categorical determinations. When NF level of care is determined appropriate categorically, the individual may be conditionally admitted prior to completion of the determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions, which cannot exceed thirty (30) consecutive days in one (1) calendar year. (11-6-93)

(2) Specialized services. Specialized services for mental illness as defined in 42 CFR 483.120(a)(1),

and for mental retardation as defined in 42 CFR 483.120(a)(2), are those services provided by the state which due to the intensity and scope can only be delivered by personnel and programs which are not included in the specialized rehabilitation services required of nursing facilities under 42 CFR 483.45. The need for specialized services must be documented and included in both the resident assessment instrument and the plan of care. (11-6-93)

(a) Individual determinations. Must be based on evaluations and data as required by these rules. (11-6-93)

(b) Group determinations. Categorical determinations that specialized services are not needed may be made in those situations permitted by 42 CFR 483.130. The same time limits, imposed by Subsection 160.06.b.v.(a)(2) shall apply. (11-6-93)

vi. Penalty for non-compliance. No payment shall be made for any services rendered by a NF prior to completion of the Level I screen and, if required, the Level II screen. Failure to comply with PASARR requirements for all individuals admitted or seeking admission may also subject a NF to other penalties as part of certification action under 42 CFR 483.20. (11-6-93)

vii. Appeals. Discharges, transfers, and preadmission screening and additional resident review (PASARR) determinations may be appealed to the extent required by 42 CFR, Part 483, Subpart E, which, pursuant to Idaho Code, 67-5229, is incorporated by reference herein. Appeals under this paragraph shall be made in accordance with the fair hearing provisions of the Idaho Department of Health and Welfare, "Rules Governing Contested Case Proceedings and Declaratory Rulings," IDAPA 16, Title 05, Chapter 03, Section 300. A Level I finding of MI or MR is not an appealable determination. It may be disputed as part of a Level II determination appeal. (10-20-96)T

viii. Automatic repeal. In the event that the Preadmission Screening and Annual Resident Review program is eliminated or made non-mandatory by act of congress, the provisions of Subsection 160.06.b. of this chapter shall cease to be operative on the effective date of any such act, without further action. (11-6-93)

07. Provider Application and Certification. (1-16-80)

a. A facility can apply to participate as a nursing facility. (7-1-94)

b. A facility can apply to participate as an ICF/MR facility. (1-16-80)

08. Licensure and Certification. (7-13-89)

a. Upon receipt of an application from a facility, the Licensing and Certification Agency must conduct a survey to determine the facility's compliance with certification standards for the type of care the facility proposes to provide to MA recipients. (7-13-89)

b. If a facility proposes to participate as a skilled nursing facility, Medicare (Title XVIII) certification and program participation is required before the facility can be certified for Medicaid. The Licensing and Certification Agency must determine the facility's compliance with Medicare requirements and recommend certification to the Medicare Agency. (7-1-94)

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care or ICF/MR, the Section must certify to the appropriate branch of government that the facility meets the standards for NF or ICF/MR types of care. (7-1-94)

d. Upon receipt of the certification from the Licensing and Certification Agency, the Bureau may enter into a provider agreement with the long-term care facility. (7-13-89)

e. After the provider agreement has been executed by the Facility Administrator and by the Chief of the Bureau, one (1) copy must be sent by certified mail to the facility and the original is to be retained by the Bureau. (11-10-81)

09. Determination of Entitlement to Long-Term Care. Entitlement to MA participation in the cost of long-term care exists when the individual is eligible for MA and the RNR has determined that the individual meets the criteria for NF or ICF/MR care and services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a recipient of or an applicant for MA. (7-1-94)

a. The criteria for determining a MA recipient's need for either nursing facility care or intermediate care for the mentally retarded must be as set forth in Subsections 180.03 or 180.08. In addition, the IOC/UC nurse must determine whether a MA recipient's needs could be met by non-inpatient alternatives including, but not limited to, remaining in an independent living arrangement or residing in a room and board situation. (7-1-94)

b. The recipient can select any certified facility to provide the care required. (11-10-81)

c. The final decision as to the level of care required by a MA recipient must be made by the IOC/UC Nurse. (7-1-94)

d. The final decision as to the need for DD or MI active treatment must be made by the appropriate Department staff as a result of the Level II screening process. (7-13-89)

e. No payment must be made by the Department on behalf of any eligible MA recipient to any long-term care facility which, in the judgment of the IOCT/UCT is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (7-1-94)

10. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for MA is entitled to MA participation in the cost of long-term care, and that the facility selected by the recipient is licensed and certified to provide the level of care the recipient requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. (7-1-94)

161. HOSPITAL SWING-BED REIMBURSEMENT.

The Department will pay for NF care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to recipients who require NF level of care as defined by Subsection 180.03 in licensed hospital ("swing") beds. (7-1-94)

01. Facility Requirements. The Department will approve hospitals for NF care provided to eligible recipients under the following conditions: (7-1-94)

a. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.66 "Special Requirements" for hospital providers of long-term care services ("swing-beds"); and (8-23-90)

b. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (5-1-84)

c. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (8-23-90)

d. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (8-23-90)

e. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.66(a)(1) for swing-bed purposes; and (8-23-90)

f. NF services in swing-beds must be rendered in beds used interchangeably to furnish hospital or NF type services. (7-1-94)

02. Recipient Requirements. The Department will reimburse hospitals for recipients under the following conditions: (5-1-84)

- and
- a. The recipient is determined to be entitled to such services in accordance with Subsection 080.01; (7-1-94)
 - b. The recipient is authorized for payment in accordance with Subsection 160.10; and (12-31-91)
03. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (8-23-90)
- a. Payment rates for routine NF services will be at the weighted average Medicaid rate per patient day paid to hospital based NF/ICF facilities for routine services furnished during the previous calendar year. ICF/MR facilities' rates are excluded from the calculations. (7-1-94)
 - b. The rate will be calculated by the Department by March 15th of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (8-23-90)
 - c. The weighted average rate for NF swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (7-1-94)
 - d. Routine services as addressed in Subsection 160.01.a. include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." (7-1-94)
 - e. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (8-23-90)
 - f. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 126. (7-1-94)
 - g. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (8-23-90)

04. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with Subsection 160.03. (12-31-91)

162. ADMINISTRATIVELY NECESSARY DAY (AND).

An Administratively Necessary Day is intended to allow a hospital time for an orderly transfer or discharge of recipient 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 NF level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (7-1-94)

01. Documentation Provided. The hospital will provide the Department's designee complete and timely documentation prior to the patient's anticipated discharge date in order to be considered. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing, or by telephone. Hospitals must make the documentation and related information requested by the Department's Medicaid Policy Section designee available within ten (10) working days of the date of the designee's request in order for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to: (4-24-90)

- a. A brief summary of the patient's medical condition; and (4-24-90)

b. Statements as to why the patient cannot receive the necessary medical services in a nonhospital setting; and (4-24-90)

c. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. (4-24-90)

02. Limitation of Administratively Necessary Days. Each recipient is limited to no more than three (3) ANDs per discharge. In the event that a NF level of care is required, an AND may be authorized provided that the hospital documents that no NF bed is available within twenty-five (25) miles of the hospital. (7-1-94)

03. Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation. (7-1-94)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (4-24-90)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (7-1-94)

c. The Department will pay the lesser of the established AND rate or a facility's customary charge to private pay patients for an AND. (4-24-90)

04. Reimbursement for Services. Routine services as addressed in Subsection 161.01.a. include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 126. (7-1-94)

163. -- 164. (RESERVED).

165. RELATIONSHIP OF MEDICAL ASSISTANCE TO MEDICARE.

01. General Relationship. In processing MA payments in behalf of recipients eligible for Medicare, the Department must determine the availability of resources from both Parts A and B of Title XVIII. The Department is to pay only the deductible and co-insurance amounts of those services covered by Parts A and B. (11-10-81)

02. "Buy-In" Coverage. The Department has an agreement with the Social Security Administration to pay the premiums for Part B of Title XVIII for each recipient eligible for Medicare and MA regardless of whether the client receives a financial grant from the Department. (6-1-91)

a. The effective date of the "Buy-In" for a client approved for MA and an AABD grant is the first month of eligibility for the AABD grant. (6-1-91)

b. The effective date of the "Buy-In" for a client approved for MA who also receives SSI, but not AABD, is the first month of eligibility for MA. (6-1-91)

c. The effective date of the "Buy-In" for a client approved for MA who does not receive an AABD grant or SSI is the first day of the second month following the month in which he became eligible for MA (third month of MA eligibility). (6-1-91)

d. After the effective date of the "Buy-In" it takes the Social Security Administration approximately three (3) months to update its records to show the Department's payment of the "Buy-In" premium. (11-10-81)

e. The Field Office will advise each recipient who is paying Part B Medicare premiums to discontinue payments beginning the month the "Buy-In" becomes effective. Policies for treatment of the "Buy-In" for determining eligibility for MA or AABD, grant amount for AABD, or patient liability are in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Policies for treatment of the "Buy-In" for determining client participation of an HCBS client are found in Subsection 160.03.e. (7-1-94)

166. -- 169. (RESERVED).

170. RELATIONSHIP OF MEDICAL ASSISTANCE TO DEPARTMENT OF VOCATIONAL REHABILITATION.

The Department has entered into agreements with DVR regarding areas of responsibility, joint planning, referrals, coordination, consultation, exchange of information and other matters of mutual concern. (11-10-81)

171. -- 179. (RESERVED).

180. INSPECTION OF CARE/UTILIZATION CONTROL IN LONG-TERM CARE FACILITIES.

The following sections describe the Inspection of Care/Utilization Control (IOC/UC) process which must be followed for admission to and continued stay in a nursing facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). (7-1-94)

01. Prepayment Screen and Determination of Entitlement to Medicaid Payment for NF Care and Services. (7-1-94)

a. A determination of medical entitlement will not be made until a medical history, physical, and plan of care signed and dated by the physician, a physician's certification for NF care, and the Level I screen and when required, the Level II screen conducted by the Department indicating that NF placement is appropriate have been received in the Regional Medicaid Unit (RMU). The effective date of Medicaid payment will be no earlier than the date of the physician's certification for NF care. The level of care for Title XIX payment purposes is determined by the Regional Nurse Reviewer(s). Necessity for payment is determined in accordance with 42 CFR 456.271 and 42 CFR 456.372 and Section 1919(e) (7) (0) of the Social Security Act. (7-1-94)

b. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the RMU will not be earlier than the date the Level II screen is completed, indicating that NF placement is appropriate. (7-1-94)

02. Information Required for Determination. (7-1-94)

a. A complete medical evaluation current within thirty (30) days of admission, signed and dated by the physician (an electronic physician's signature is permissible), which includes: (7-1-94)

i. Diagnosis (primary and secondary); and (7-1-94)

ii. Medical findings and history; and (7-1-94)

iii. Mental and physical functional capacity; and (7-1-94)

iv. Prognosis; and (7-1-94)

v. A statement by the physician certifying the need for NF care and services. (7-1-94)

b. A physician's plan of care current within thirty (30) days of admission, signed and dated by the physician, which includes: (7-1-94)

i. Orders for medications and treatments; and (7-1-94)

- ii. Diet and activities; and (7-1-94)
- iii. Rehabilitative, restorative services, and special procedures, where appropriate; and (7-1-94)
- iv. Plan of continuing care and discharge, where appropriate. (7-1-94)
- c. Social information submitted by one (1) of the following: (7-1-94)
 - i. The physician; or (7-1-94)
 - ii. The applicant or family member; or (7-1-94)
 - iii. Health and Welfare agency worker; or (7-1-94)
 - iv. Facility social worker or R.N. (7-1-94)
 - d. An accurate Level I screen and, when required, a Level II screen. (7-1-94)
- 03. Criteria for Determining Need for NF Care. The recipient requires NF level of care when one or more of the following conditions exist and the skills of an R.N., P.T., or O.T. are required on a daily or regular basis: (7-1-94)
 - a. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and/or effectively performed only by or under the supervision of a licensed nurse or licensed physical therapist. (7-1-94)
 - b. Skilled care is needed to prevent, to the extent possible, deterioration of the resident's condition or to sustain current capacities, regardless of the restoration potential of a resident, even where full recovery or medical improvement is not possible. (7-1-94)
 - c. When the plan of care, risk factors, and/or aggregate of health care needs is such that the assessments, interventions, or supervision of the resident 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/or therapy notes. (7-1-94)
- 04. Skilled Nursing and Other Skilled Rehabilitative Services. Skilled services include the following: ()
 - a. Services which could qualify as either skilled nursing or skilled rehabilitative services, which include: ()
 - i. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet his needs, promote his recovery, and assure his medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that his recovery and/or safety could be assured only if the total care he requires is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (7-1-94)
 - ii. Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized, such services constitute skilled services. (7-1-94)
 - b. Services which qualify as skilled nursing services include the following: ()

- i. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; and (7-1-94)
- ii. Nasopharyngeal feedings; and (7-1-94)
- iii. Nasopharyngeal and tracheotomy aspiration; and (7-1-94)
- iv. Insertion and sterile irrigation and replacement of catheters; and (7-1-94)
- v. Application of dressings involving prescription medications and/or aseptic techniques; and (7-1-94)
- vi. Treatment of extensive decubitus ulcers or other widespread skin disorders; and (7-1-94)
- vii. Heat treatments which have been specifically ordered by a physician as part of treatment and which require observation by nurses to adequately evaluate the resident's progress; and (7-1-94)
- viii. Initial phases of a regimen involving administration of oxygen. (7-1-94)
- c. Services which qualify as skilled rehabilitative services include the following: ()
 - i. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; and (7-1-94)
 - ii. Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; and (7-1-94)
 - iii. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (7-1-94)
 - iv. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist; and (7-1-94)
 - v. Hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (7-1-94)
- 05. Annual Utilization Control Review. Title XIX recipients in a NF are subject to an on-site review by Regional Nurse Reviewers within ninety (90) days of the date of medical entitlement, and in one (1) year after medical entitlement to determine the need for continued NF care. Reviews will be conducted each calendar quarter on selected Title XIX recipients and other residents mandated by PASARR. ()
 - a. Selection of recipients/residents to be reviewed each quarter: (7-1-94)
 - i. Recipients to be reviewed within ninety (90) days of date of initial medical entitlement; and (7-1-94)
 - ii. Recipients whose medical entitlement one (1) year anniversary date falls within the quarter; and ()
 - iii. Recipients/residents who have a Level II evaluation, with an admission anniversary date that falls within the quarter; and (7-1-94)

- iv. Recipients who are receiving services that require a special Medicaid rate; and (7-1-94)
- v. Recipients identified during previous reviews whose improvement may remove the need for continuing NF care. (7-1-94)
- b. The on-site review conducted by the Regional Nurse Reviewer will include the following components: (7-1-94)
 - i. Entrance and exit conferences with appropriate facility personnel unless such conference is waived by the administrator; and (7-1-94)
 - ii. A review of the critical indicators in the Minimum Data Set section of the recipient's medical record; and (7-1-94)
 - iii. A visit with and observation of each recipient's condition; and (7-1-94)
 - iv. A determination whether the recipient continues to require nursing facility care; and (7-1-94)
 - v. A determination that those recipients or residents who warrant a Level II evaluation continue to require nursing facility care. (7-1-94)
- 06. Preadmission Screening and Determination of Entitlement for Medicaid ICF/MR Payment. Applications for Medicaid payment of an individual with mental retardation, or related condition, in an ICF/MR will be through a State's Regional Developmental Disabilities Centers (DDC). All required information necessary for a medical entitlement determination, including DDC's recommendation for placement and services, must be submitted to the Regional Medicaid Unit 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/MR level of care. (7-1-94)
- 07. Information Required for Determination. (7-1-94)
 - a. A complete medical evaluation, current within ninety (90) days of admission, signed and dated by the physician, an electronic physician's signature is permissible, which includes: ()
 - i. Diagnosis (primary and secondary); and (7-1-94)
 - ii. Medical findings and history; and (7-1-94)
 - iii. Mental and physical functional capacity; and (7-1-94)
 - iv. Prognosis; and (7-1-94)
 - v. Mobility status; and (7-1-94)
 - vi. A statement by the physician certifying the level of care needed as ICF/MR for a specific recipient. (7-1-94)
 - b. An initial plan of care, current within ninety (90) days of admission and signed and dated by the physician which includes: (7-1-94)
 - i. Orders for medications and treatments; and (7-1-94)
 - ii. Diet; and (7-1-94)
 - iii. Professional rehabilitative and restorative services and special procedures, where appropriate. (7-1-94)

- c. A social evaluation, current within ninety (90) days of admission, which includes: (7-1-94)
 - i. Condition at birth; and (7-1-94)
 - ii. Age at onset of condition; and (7-1-94)
 - iii. Summary of functional status, e.g. skills level, ADLs; and (7-1-94)
 - iv. Family social information. (7-1-94)
 - d. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, which includes: ()
 - i. Diagnosis; and (7-1-94)
 - ii. Summary of developmental findings. Instead of a psychological, infants under three (3) years of age may be evaluated by a developmental disability specialist utilizing the developmental milestones congruent with the age of the infant; and (7-1-94)
 - iii. Mental and physical functioning capacity; and (7-1-94)
 - iv. Recommendation concerning placement and primary need for active treatment. (7-1-94)
 - e. An initial plan of care developed by the admitting ICF/MR. (7-1-94)
08. Criteria for Determining ICF/MR Care. To meet Title XIX entitlement for intermediate care for the mentally retarded (ICF/MR) level of care, the person must be financially eligible for Medicaid and meet all of the following criteria: (7-1-94)
- a. The person must have a primary diagnosis of mental retardation or have a related condition defined in Subsection 181.09 of these rules; and ()
 - b. The person must require and receive intensive inpatient active treatment as defined in Subsection 181.10, in an ICF/MR, to advance or maintain his functional level; or (7-1-94)
 - c. The person would require the level of care provided in an ICF/MR in the absence of available intensive alternative services in the community. (7-1-94)
09. Definition of Mental Retardation or Related Condition. For the purposes of these rules, the term "mental retardation or related condition" means a severe, chronic disability of a person which appears before the age of twenty-two (22) years of age; and (7-1-94)
- a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. This condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and (7-1-94)
 - b. Is likely to continue indefinitely; and (7-1-94)
 - c. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: (7-1-94)
 - i. Self-care; or (7-1-94)
 - ii. Receptive and expressive language; or (7-1-94)
 - iii. Learning; or (7-1-94)

- iv. Mobility; or (7-1-94)
- v. Self-direction; or (7-1-94)
- vi. Capacity for independent living; or (7-1-94)
- vii. Economic self-sufficiency. (7-1-94)
- 10. Determination of Need for Active Treatment. (7-1-94)
 - a. Active treatment, as used in these rules, 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 Mental Retardation Professional (QMRP) directed toward: (7-1-94)
 - i. The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or (7-1-94)
 - ii. The prevention or deceleration of regression or loss of current functional status. (7-1-94)
 - b. Active treatment does not include: (7-1-94)
 - i. Parenting activities directed toward the acquisition of age-appropriate developmental milestones; or (7-1-94)
 - or
 - ii. Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; or (7-1-94)
 - iii. Interventions that address age-appropriate limitations; or (7-1-94)
 - iv. General supervision of children who's age is such that such supervision is required by all children of the same age. (7-1-94)
 - c. The following criteria/components will be utilized when evaluating the need for active treatment: (7-1-94)
 - i. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the recipient and the interventions needed; and (7-1-94)
 - ii. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (7-1-94)
- 11. Recertification for ICF/MR Level of Care. A physician or physician's assistant or nurse practitioner must recertify the resident's continuing need for ICF/MR placement by written, signed, and dated documentation in the resident's medical record. Documentation will consist of the completion of a recertification statement on the "Recertification of Care" HW0209 and/or the entry of all required information on the physician's order sheet. Such documentation shall be accomplished no later than every three hundred sixty-five (365) days from the most recent such certification. (7-1-94)
 - a. It is the responsibility of the ICF/MR to assure that the recertification is accomplished by the physician, physician's assistant or nurse practitioner no later than every three hundred sixty-five (365) days. Should the Medicaid Program receive a financial penalty from the Department of Health and Human Services due to the lack of appropriate recertification on the part of an ICF/MR, then such amount of money will be withheld from facility payments for services provided to Medicaid recipients. For audit purposes, such financial losses are not reimbursable as a reasonable cost of patient care. Such losses cannot be made the financial responsibility of the Department's client. (7-1-94)

b. The physician's, physician's assistant's, or nurse practitioner's recertification will be monitored by the IOCT at the time of the annual on-site review. (7-1-94)

12. Annual Inspection of Care Review. Each Title XIX resident will receive an on-site comprehensive Inspection of Care review at least annually. (7-1-94)

a. Each Title XIX resident's medical record and plan of care will be reviewed to determine the quality of care and services rendered to the resident. The plan of care must include: (7-1-94)

i. Behaviorally stated measurable goal and objectives; and (7-1-94)

ii. An integrated program of individually designed activities, experiences, and therapies necessary to achieve such goals and objectives. (7-1-94)

b. Observation and/or interview with each Title XIX resident as deemed appropriate; and (7-1-94)

c. A determination of each resident's level of care. The IOCT determines the appropriateness of level of care for the purpose of Medicaid payment; and (7-1-94)

d. Evaluation of services provided by the facility to determine that each individual resident's needs are met; and (7-1-94)

e. Verification of recertifications to determine if the physician, physician's assistant, or a nurse practitioner recertified the resident's continuing need for ICF/MR care within the required time frames and is signed and dated by the certifying physician, physician's assistant, or a nurse practitioner. (7-1-94)

13. Inspection of Care Reports. (7-1-94)

a. The IOCT will prepare a full and complete report following the annual on-site review in each ICF/MR. The report will be forwarded to the following no later than thirty (30) days after the on-site review: (7-1-94)

i. Facility administrator; and (7-1-94)

ii. Facility Utilization Review Committee; and (7-1-94)

iii. Medicaid single state agency; and (7-1-94)

iv. Agency responsible for licensing and certification. (7-1-94)

b. A formal response is required from the facility regarding the IOC deficiencies requiring correction. The Department will specify the amount of time a facility will be allowed to respond which will not exceed thirty (30) days. An extension of time may be granted, not to exceed an additional thirty (30) days if the Department concludes that such an extension is in the best interests of the residents of the facility. The formal response is to be returned to the Regional Medicaid Unit. (7-1-94)

14. Level of Care Change. Level of care is the level of NF or ICF/MR services provided to meet the patient's/resident's medical, nursing, rehabilitative and/or habilitative care needs. (7-1-94)

a. If during an on-site review of a resident's medical record and an interview with or observation of the resident an IOC/UC reviewer determines there is a change in the resident's status and the resident no longer meets criteria for NF or ICF/MR care, the tentative decision is: (7-1-94)

i. Discussed with the facility administrator and/or the director of nursing services; and (7-1-94)

ii. The patient's/resident's physician is notified of the tentative decision; and (7-1-94)

- iii. The case is submitted to the Regional Review Committee for a final decision; and (7-1-94)
- iv. When NF or ICF/MR care is determined to be not necessary for applicants or no longer necessary or appropriate for a recipient, the Regional Medicaid Unit will notify the local Eligibility Field Office utilizing the HW0083 form that the applicant/recipient is not medically entitled to Medicaid payment. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the recipient by the Eligibility Examiner. (7-1-94)
- 15. Appeal of Determinations. The resident or his representative may appeal the decisions as set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 000, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings." ()
- 16. Regional Review Committee. A committee established in each region to provide thorough and impartial reviews and final determinations on cases submitted by the Regional Medicaid Unit which includes: ()
 - a. A resident's continued medical entitlement to NF or ICF/MR care that is no longer recommended by the Regional Nurse Reviewer. (7-1-94)
 - b. Applications for medical entitlement where the level of care, client safety, or the effectiveness of care appears to be questionable. (7-1-94)
 - c. All denial decisions recommended by the Regional Nurse Reviewer. (7-1-94)
 - d. The Committee may continue, terminate the client's Medicaid payments, or recommend a supplemental on-site visit by the Regional Nurse Reviewer if it is deemed necessary. (7-1-94)
 - e. No review of a denial of payment is required of the Committee when the denial is based on the level of care determination by the attending physician, i.e. the physician documents that the applicant/recipient does not require NF or ICF/MR level of care. (7-1-94)
 - f. The Regional Review Committee shall be composed of the following: (7-1-94)
 - i. A consultant physician; and (7-1-94)
 - ii. Two (2) registered nurses; and (7-1-94)
 - iii. A social worker when necessary; and (7-1-94)
 - iv. A qualified mental retardation professional (QMRP) or a qualified mental health professional (QMHP) when necessary; and (7-1-94)
 - v. When appropriate, other health and human service personnel responsible to the Department as employees or consultants. (7-1-94)
- 17. Supplemental On-Site Visit. The Regional Nurse Reviewer(s) may conduct UC supplemental on-site visits in a NF, or IOC supplemental on-site visits in an ICF/MR when indicated. Some indications may be: ()
 - a. Follow-up activities; and (7-1-94)
 - b. A verification of a recipient's appropriateness of placement and/or services; and (7-1-94)
 - c. Conduct complaint investigations at the Department's request. (7-1-94)
- 181. -- 184. (RESERVED).

185. MEDICAL CARE ADVISORY COMMITTEE.

The Director of the Department will appoint a Medical Care Advisory Committee to advise and counsel on all aspects of health and medical services. (11-10-81)

01. Membership. The Medical Care Advisory Committee will include, but not be limited to, the following: (11-10-81)

a. Licensed physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; and (11-10-81)

b. Members of consumer groups, including MA recipients and consumer organizations. (11-10-81)

02. Organization. The Medical Care Advisory Committee will: (11-10-81)

a. Consist of not more than twenty-two (22) members; and (11-10-81)

b. Be appointed by the Director to the Medical Care Advisory Committee to serve three (3) year terms, whose terms are to overlap; and (11-10-81)

c. Elect a chairman and a vice-chairman to serve a two (2) year term; and (11-10-81)

d. Meet at least quarterly; and (11-10-81)

e. Submit a report of its activities and recommendations to the Director at least once each year. (11-10-81)

03. Policy Function. The Medical Care Advisory Committee must be given opportunity to participate in MA policy development and program administration. (11-10-81)

04. Staff Assistance. The Medical Care Advisory Committee must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. (11-10-81)

186. -- 189. (RESERVED).

190. PROGRAM INTEGRITY.

01. Purpose. This section is intended to protect the integrity of the state plan by identifying instances of fraud, abuse, over-utilization and other misconduct by providers and their employees, and recipients, and by providing that appropriate action be taken to correct the problem. Action will be taken to protect both program recipients and the financial resources of the plan. Where minimum federal requirements are exceeded, it is the Department's intent to provide additional protections. Nothing contained herein shall be construed to limit the Department from taking any other action authorized by law, including, but not limited to, seeking damages under Idaho Code Section 56-227B. (11-6-93)

02. Authority. (11-6-93)

a. 42 CFR, Part 455, requires states to identify, investigate and refer suspected cases of fraud and abuse. (11-6-93)

b. 42 CFR, Part 1002, requires states to adopt procedures which enable it to exclude a person for any reason for which the secretary of HHS could exclude such person. Additionally, it authorizes states to identify its own reasons and periods for imposing sanctions. (11-6-93)

c. Idaho Code, 15-134 authorizes the Director to deny, suspend, or revoke provider status, and to impose monetary penalties against certain providers in specific instances. (11-6-93)

d. 42 CFR, Part 456, requires states to implement programs to safeguard against unnecessary or inappropriate use of services, excessive payments, and to assure the quality of services. (11-6-93)

e. 42 CFR, Part 433, imposes requirements on states to collect overpayments made to providers. (11-6-93)

f. Idaho Code, 56-202(b) and 56-135 require the Department to promulgate, adopt and enforce rules and methods of administration to carry out the purposes of the state plan. (11-6-93)

g. Idaho Code, 56-227(e) requires the Department to establish and operate a fraud control program to monitor public assistance programs. (11-6-93)

h. 42 CFR Section 431.54(e) authorizes states to restrict recipients to designated providers when the recipients have utilized services at a frequency or amount that is not medically necessary, or in accordance with utilization guidelines established by the state. (11-6-93)

03. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (11-6-93)

a. Abuse. Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (11-6-93)

b. Claim. An application submitted by a person to the Department, or an agent thereof, for payment of an item or service under the state plan for medical assistance, including, but not limited to, those forms identified in Subsection 003.10 of this chapter. (11-6-93)

c. Exclusion. A specific provider will be precluded from providing services and receiving reimbursement under Medicaid. (11-6-93)

d. False claim. Any incorrect claim for items or services, including any misstatement or misrepresentation of a material fact on a cost report, without regard to the intent of the maker. This includes, but is not limited to, reporting costs as allowable which were disallowed in previous audits, unless clearly noted. (11-6-93)

e. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (11-6-93)

f. Item or Service. Includes (a) any item, device, medical supply or service claimed to have been provided to a patient and listed in an itemized claim for program payment or a request for payment, and (b) in the case of a claim based on costs, any entry or omission in a cost report, books of account or other documents supporting the claim. (11-6-93)

g. Medical Assistance. Shall mean payments for part or all of the cost of such care and services allowable within the scope of Title XIX of the federal Social Security Act as amended as may be designated by Department rules. (11-6-93)

h. Owner. A person having five percent (5%) or more interest in the facility or provider organization. (11-6-93)

i. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (11-6-93)

j. PRO. Any peer review organization. (11-6-93)

- k. Program. The Medicaid Program or any part thereof, including Idaho's state plan. (11-6-93)
- l. Recoup and Recoupment. That payment of provider claims will be withheld for the purpose of recovering funds which have been paid for items or services the Department has subsequently determined should not have been paid. (11-6-93)
- m. Sanction. Any abatement or corrective action taken by the Department which is appealable under Subsection 190.05 of this section. (11-6-93)
- n. State plan. The Medicaid program as it exists in Idaho. (11-6-93)
- o. Suspension. The temporary barring of a person from participation in the Medicaid program pending further or additional action. (11-6-93)
- 04. Methodology. The Department will identify potential instances of fraud, abuse, over-utilization and other misconduct by any person related to involvement in the program. Methods may include, but are not limited to, review of computerized reports, referrals from other agencies, health care providers or persons, or conducting audits. Reviews may occur on either prepayment or postpayment basis. (11-6-93)
 - a. Surveillance and Utilization Review (S/UR) Committee. Instances of suspected fraud, abuse, over-utilization and other misconduct may be referred to a review committee organized by the Department. The committee shall be chaired by the Director's designee, and shall consist of health professionals and other staff nominated to and accepted by the committee. The committee may also consult with other professionals as necessary. The function of the committee will be to review recommendations concerning corrective action. (11-6-93)
 - b. Corrective Action. When an instance of fraud, abuse, over-utilization or other misconduct is identified, the Department will take action to correct the problem as provided in this section. Such action may include, but is not limited to, exclusion, suspension, recoupment, denial of payment, imposition of civil monetary penalties, termination of provider agreement, provider lock-in, and referral for prosecution and/or to state licensing boards. (11-6-93)
- 05. Provider Review. (11-6-93)
 - a. Denial of Payment and Recoupment. The Department shall refuse to pay any and all claims it determines are for items or services: (11-6-93)
 - i. Not provided or not medically necessary; (11-6-93)
 - ii. Not documented to be provided or medically necessary; (11-6-93)
 - iii. Not provided in accordance with professionally recognized standards of health care; (11-6-93)
 - iv. Not covered by the state plan; or (11-6-93)
 - v. Provided contrary to the Rules Governing Medical Assistance, the Provider Reimbursement manual, or the provider agreement. If payment has been made, the Department shall recoup the amount paid for these items or services. If recoupment is impracticable, the Department may pursue any available legal remedies it may have. (11-6-93)
 - b. Mandatory Exclusions. The Department shall exclude any person that: (11-6-93)
 - i. Has committed a criminal offense related to the delivery of an item or service under Medicare or any State health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program; (11-6-93)
 - ii. Has been convicted, under federal or state law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the

Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program beneficiary; or (11-6-93)

iii. Is identified by HCFA as having been excluded by another state or the Office of Inspector General or any person HCFA directs the Department to exclude. No mandatory exclusion imposed pursuant to paragraphs i or ii, will be for less than ten (10) years. The exclusion may exceed ten (10) years aggravating factors are present. For purposes of Subsection 190.05.b.i., a person has committed a criminal offense if he has committed an act defined as a criminal offense under any federal, state or local law, whether or not he/she has been convicted of said offense in a criminal proceeding. (11-6-93)

c. Permissive Exclusions. The Department may exclude any person: (11-6-93)

i. That has had action taken against them by a state licensing board, including, but not limited to suspension, in which case, the period of the exclusion shall not be less than the period of suspension by the licensing board; (11-6-93)

ii. That has been identified by a peer review group or organization as endangering the health and/or safety of a patient; (11-6-93)

iii. That has failed or refused to disclose or make available to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained the Department deems relevant to determining the appropriateness of payment except for records privileged under Idaho Code Section 39-1392b;or (11-6-93)

iv. For any reason for which the Secretary of Health and Human Services, or his designee, could exclude under parts 1001 or 1003, 42 CFR. Permissive exclusions will be for a period of five (5) years, unless aggravating or mitigating factors form a basis for lengthening or shortening that period. (11-6-93)

d. Aggravating and Mitigating Factors. For purposes of lengthening the period of mandatory exclusions and lengthening or shortening the period of permissive exclusions, the following factors will be considered: (11-6-93)

i. Aggravating Factors. (11-6-93)

(1) The acts resulting in the conviction, or similar acts, resulted in financial loss to the program of one thousand five hundred dollars (\$1,500) or more. (The entire amount of financial loss to such program will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the programs); (11-6-93)

(2) The acts that resulted in the conviction, or similar acts, were committed over a period of one (1) year or more; (11-6-93)

(3) The acts that resulted in the conviction, or similar acts, had a significant adverse physical, mental or financial impact on one (1) or more program recipients or other individuals; (11-6-93)

(4) Any sentence imposed by the court related to the same act; (11-6-93)

(5) The excluded person has a prior criminal, civil or administrative sanction record; or (11-6-93)

(6) The person has at any time been overpaid a total of one thousand five hundred dollars (\$1,500) or more by Medicare or state health care programs as a result of improper billings. (11-6-93)

ii. Mitigating Factors. (11-6-93)

(1) The person committed a misdemeanor offense, or the entire amount of financial loss to Medicare and the State health care programs due to the acts that resulted in the conviction, and similar acts, is less than one thousand five hundred dollars (\$1,500); (11-6-93)

(2) The record demonstrates that the person had a mental, emotional or physical condition before or during the commission of the offense that reduced the individual's culpability (the fact that such a condition existed does not necessarily reduce the individual's culpability); or (11-6-93)

(3) The person's cooperation with federal or state officials resulted in administrative sanctions or criminal charges being filed against other persons. (11-6-93)

e. Civil Monetary Penalties. The Department may assess, in lieu of exclusion, or in addition thereto, monetary penalties of a civil nature against any provider, facility, owner, officer, director or managing employee, who: (11-6-93)

i. Fails or refuses to comply with the rules and regulations governing medical assistance; (11-6-93)

ii. Knowingly, or with reason to know, makes a false statement of a material fact in any record required to be filed under the state plan; each false statement shall be considered a separate violation, even if included in the same submission; (11-6-93)

iii. Refuses to allow representatives or agents of the Department to inspect any record, book, or file maintained by the provider or required of the provider to be maintained which, in the Department's judgment, is necessary to determine appropriateness of payments; (11-6-93)

iv. Willfully prevents, interferes with or attempts to impede in any way the work of any duly authorized representative or agent of the Department; or (11-6-93)

v. Willfully destroys any evidence of any violation of the rules governing medical assistance. Assessments shall be one thousand dollars (\$1000) per violation unless reduced by mitigating factors. Mitigating factors may include, but are not limited to, the nature and circumstances of the incident, the degree of culpability, lack of prior offenses or other wrongful conduct, and the financial condition of the offender. (11-6-93)

f. Miscellaneous Corrective Actions. The Department may take lesser action to investigate, monitor and correct suspected instances of fraud, abuse, over-utilization, and other misconduct, including, but not limited to: (11-6-93)

i. Issuance of a warning letter describing the nature of suspected violations, and requesting an explanation of the problem and/or a warning that additional action may be taken if the action is not justified or discontinued; (11-6-93)

ii. Prepayment review of all or selected claims submitted by the provider with notice that claims failing to meet written guidelines will be denied; (11-6-93)

iii. Referral to state licensing boards for review of quality of care and professional and ethical conduct; (11-6-93)

or

iv. Termination of provider agreements. (11-6-93)

g. Immediate Action. (11-6-93)

i. Suspension of payments pending investigation. In the event the Department identifies a suspected case of fraud, abuse, over-utilization, or other misconduct which requires further investigation, and determines that a substantial possibility exists that payments made during the investigation will be difficult or impractical to recover, the Department may suspend or withhold payments on any pending or subsequent claims while the provider continues to participate in the program. (11-6-93)

ii. Interim Suspension. In the event the Department identifies a suspected case of fraud, abuse, over-utilization, or other misconduct, the Department may summarily suspend a provider or employee of a provider if it determines that it is necessary to prevent or avoid immediate danger to the public health, safety, or welfare. Such a

finding will be incorporated in the order. The provider shall be given notice but the order is effective when issued. (11-6-93)

iii. Appeal of Immediate Action. Whenever action is taken under Subsection 190.01.g., a hearing will be held within thirty (30) days of receipt of any duly filed notice of appeal, if any appeal is made. (11-6-93)

h. Disclosure of Certain Persons. Prior to entering into or renewing a provider agreement, or at any time upon written request by the Department, a provider must disclose to the Department the identity of any person described at 42 CFR 1001.1001. The Department may refuse to enter into or renew an agreement with any provider associated with any person so described. The Department may also refuse to enter into, or terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under this subsection. (11-6-93)

i. Notification of Exclusions. (11-6-93)

i. Provider Notification. When the Department determines exclusion is appropriate, it will send written notice of the decision to the person so excluded. The notice will state the basis for the exclusion, the length of the exclusion, the effect of the exclusion on that person's ability to provide services under state and federal programs, and the person's appeal rights. (11-6-93)

ii. Notice to State Licensing Authorities. The Department will promptly notify all appropriate licensing authorities having responsibility for licensing or certification of a person excluded from participation of the facts and circumstances of the exclusion. The Department may request certain action be taken and that the Department be informed of actions taken. (11-6-93)

iii. Public Notice. The Department will give notice of the exclusion and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate, including, but not limited to, related providers, the PRO, institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. (11-6-93)

iv. Department of Health and Human Services. The Department shall notify the OIG within fifteen (15) days after it learns a person has been convicted of a criminal offense related to participation in the delivery of health care items or services under the program. (11-6-93)

j. Appeals. Any exclusion, suspension, recoupment, denial of payment, civil monetary penalty, or termination of provider agreement for cause, may be appealed as a contested case pursuant to the IDAPA 16, Title 05, Chapter 03, "Rules Governing Contested Cases and Declaratory Rulings." Unless action is taken pursuant to Subsection 190.05.g., an appeal stays the action until the time to appeal the Department's final order has expired. (11-6-93)

06. Recipient Utilization Control Program. (11-6-93)

a. Purpose. The Recipient Utilization Control program is designed to promote improved and cost efficient medical management of essential health care by monitoring recipient activities and taking action to correct abuses. (11-6-93)

b. Lock-in Defined. Lock-in is the process of restricting the access of a recipient to a specific provider or providers. (11-6-93)

c. Criteria for Lock-in. (11-6-93)

i. The Department shall review recipients to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary. Evaluation of utilization patterns can include, but is not limited to, review by the Department staff of medical records and/or computerized reports generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and/or diagnostic procedures, hospital admissions, and referrals. (11-6-93)

- ii. Recipients demonstrating unreasonable patterns of utilization and/or exceeding reasonable levels of utilization shall be reviewed for restriction. (11-6-93)
- iii. Since it is impossible to identify all possible patterns of over-utilization, and since a particular pattern may be justified based on individual conditions, no specific criteria for lock-in will be developed. However, the S/UR Committee may develop guidelines for purposes of uniformity. The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over-utilization is identified. (11-6-93)
- d. Notification and Procedures of Lock-in. (11-6-93)
 - i. A recipient who has been designated by the S/UR Committee for the Recipient Utilization Control Program will be contacted by the Regional Programs Manager or designee. (11-6-93)
 - ii. The recipient shall have the opportunity to select designated provider(s) in each area of misuse and so specify on the Utilization Control Agreement form. (11-6-93)
 - iii. The Department shall not implement the continued recipient restriction if a valid appeal is noted pursuant to Subsection 190.06.f. (11-6-93)
 - iv. The Department shall restrict recipients to their designated providers for a time period determined by the S/UR Committee. Upon review at the end of that period, lock-in may be extended for an additional period determined by the S/UR Committee. (11-6-93)
 - v. Payment to provider(s) other than those specified on the Utilization Control Agreement form is limited to: Documented emergencies; or written referrals from the primary physician as designated on the Utilization Control Agreement form. (11-6-93)
 - vi. During the initial interview with the Regional Programs Manager or his designee, the recipient will be given written notification of the Department's decision to place the recipient on the Recipient Utilization Control Program which will: (11-6-93)
 - (1) Clearly describe the recipient's appeal rights in accordance with the provisions in Subsection 190.06.f.; (11-6-93)
 - (2) Specify the primary physician and the effective date of the restriction; (11-6-93)
 - (3) Verify the recipient's choice of provider(s); and (11-6-93)
 - (4) Provide the original or a copy of the Utilization Control Agreement form to the recipient. (11-6-93)
 - vii. Upon return of the notification from the Regional Programs Manager or their designee, the Department will contact the provider(s) selected to assure the provider is willing to provide the service. (11-6-93)
 - viii. Following confirmation from the provider, the medical restriction will become effective on the first day of the following month when the MA eligibility card is issued with the restrictions noted. (11-6-93)
- e. Penalties for Noncompliance. (11-6-93)
 - i. If a recipient fails to respond to the regional notification of medical restriction(s), fails to sign the Utilization Control Agreement form, or select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. (11-6-93)
 - ii. If a recipient continues to abuse and/or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. (11-6-93)

f. Appeal of Lock-in. Department determinations to lock-in a recipient may be appealed in accordance with the fair hearings provisions of the Department's "Rules Governing Contested Cases and Declaratory Rulings," IDAPA 16, Title 05, Chapter 03. (11-6-93)

07. Recipient Explanation of Medicaid Benefits (REOMBs). (11-6-93)

a. The Department will conduct monthly surveys of services rendered to MA recipients using REOMBs. (11-10-81)

b. A MA recipient is required to respond to the Department's explanation of medical benefits survey whenever he is aware of discrepancies. (11-10-81)

c. If the recipient is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on his behalf. (11-10-81)

d. Medicare-to-Medicaid Cross-over Claims. All claims processed through the cross-over system will be subject to these rules. All providers submitting cross-over claims must comply with the terms of their provider agreements. (11-10-81)

191. -- 194. (RESERVED).

195. UTILIZATION CONTROL -- HOSPITALS.

The policy, rules and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. (11-10-81)

196. -- 199. (RESERVED).

200. UTILIZATION CONTROL -- NURSING FACILITIES.

The policy, rules and regulations to be followed must be those cited in 42 CFR 456.250 through 42 CFR 456.281. (7-1-94)

201. -- 299. (RESERVED).

300. UTILIZATION CONTROL -- INTERMEDIATE CARE FACILITIES/FOR THE MENTALLY RETARDED.

The policy, rules and regulations to be followed must be those cited in 42 CFR 456.350 through 42 CFR 456.438. (7-1-94)

301. -- 399. (RESERVED).

400. UTILIZATION CONTROL -- IN-PATIENT PSYCHIATRIC SERVICES.

The policy, rules and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482. (11-10-81)

401. -- 995. (RESERVED).

996. ADMINISTRATIVE PROVISIONS.

Contested case appeals shall be governed by Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 000, et seq., "Rules Governing Contested Cases and Declaratory Rulings." (12-31-91)

997. CONFIDENTIALITY.

Before any information about a patient, client, registrant, applicant, or recipient contained in Department records can be released to the person himself, to another Departmental unit, to another governmental agency, or to a private individual or organization, the unit of the Department with custody of the record must comply with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 01, "Rules Governing Protection and Disclosure of Department Records (Confidentiality)." (11-10-81)

998. GENDER AND NUMBER.

As used in these rules, the masculine and feminine, or neuter gender, and the singular or plural number, will each be deemed to include the other whenever the context so requires. (11-10-81)

999. SEVERABILITY.

Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, are severable. If any rule, or part thereof, or the application of such rule to any person or circumstance is declared invalid, such invalidity will not affect the validity of any other provision contained herein. (11-10-81)