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**IDAPA 16
TITLE 03
CHAPTER 09**

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

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

04. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (7-1-97)

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care or IADLs. These services may include, but are not limited to, personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis or other category of disability. (3-30-01)

06. Authorized Provider. A licensed nurse practitioner, clinical nurse specialist, or physician assistant. (3-30-01)

07. **Bill.** The itemized cost of all services provided to one (1) participant on a single claim form. (3-30-01)
08. **Buy-In Coverage.** The amount the State pays for Part B of Title C XVIII on behalf of the A/R. (11-10-81)
09. **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)
10. **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)
11. **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)
12. **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)
13. **Claim.** An itemized bill for services rendered to one (1) participant by a provider submitted on any of the following Department claim forms: (3-30-01)
- 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)
14. **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)
15. **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)
16. **Contraception.** The provision of drugs or devices to prevent pregnancy. (1-16-80)
17. **Department.** The state of Idaho Department of Health and Welfare (DHW). (11-10-81)
18. **Director.** The Director of the Idaho Department of Health and Welfare. (11-10-81)
19. **Durable Medical Equipment (DME).** Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose,

is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a MA participant. (3-30-01)

20. 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 participant or required by federal and state educational statutes or regulations; are not “related services” as listed in Sections 119 and 120 of these rules; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-30-01)

21. Eligibility Manuals. IDAPA 16.03.01, “Eligibility for Health Care Assistance for Families and Children,” and IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind and Disabled”. (3-30-01)

22. 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)

23. 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)

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

25. 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 Home Health Agencies”. (3-30-01)

26. 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)

27. 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)

28. 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 participants. Such a team is composed of: (3-30-01)

- 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)

29. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-30-01)

30. 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)
- 31. Intermediate Care Facility Services.** Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-01)
- 32. Law Enforcement Authority.** An agency recognized by the state of Idaho in enforcement of established state and federal statutes. (11-10-81)
- 33. Legal Representative.** A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-01)
- 34. 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)
- 35. Licensed Psychologist.** An individual who is licensed to practice psychology under Chapter 23, Title 54, Idaho Code. (10-6-88)
- 36. 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)
- 37. Lock-In Program.** An administrative sanction, required of participant found to have misused the services provided by the Medical Assistance Program, requiring the participant to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-01)
- 38. Locum Tenens/Reciprocal Billing.** The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis not to exceed a period of fourteen (14) continuous days. (3-15-02)
- 39. 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)
- 40. Medical Necessity.** A service is medically necessary if: (7-1-98)
- 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 (7-1-98)
- 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. (7-1-98)
- 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. (7-1-98)
- 41. 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)

42. 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)

43. 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)

44. 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)

45. 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)

46. 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)

47. Orthotic. Pertaining to or promoting the straightening of a deformed or distorted part. (10-1-91)

- 48. Orthotic and Prosthetic Professional.** An individual certified or registered by the American Board for Certification in Orthotics and/or Prosthetics. (10-1-91)
- 49. Other Public Education Agency.** Charter schools and the Idaho Infant Toddler Program. (3-30-01)
- 50. Otologist.** A licensed physician who specializes in the diagnosis and treatment of hearing disorders and diseases of the ear. (11-10-81)
- 51. 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)
- 52. 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)
- 53. 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)
- 54. Participant.** An individual who is receiving Medical Assistance. (3-30-01)
- 55. Patient.** The person undergoing treatment or receiving services from a provider. (11-10-81)
- 56. Personal Assistance Agency.** An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, is the employer of record and in fact, and may provide fiscal intermediary services. (3-30-01)
- 57. Personal Assistance Services (PAS).** Services that include attendant care and personal care services. (3-30-01)
- 58. 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)
- 59. 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)
- 60. Plan of Care.** A written description of medical, remedial and/or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-30-01)

- 61. Premium or Subscription Charge.** The per capita amount paid by the Department for each eligible MA participant enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a participant receives care and services during the contract period. (3-30-01)
- 62. Property.** The homestead and all personal and real property in which the participant has a legal interest. (3-30-01)
- 63. 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)
 - d.** Computerized communication devices are not covered under the definition of a prosthetic device. (7-1-99)
- 64. 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)
- 65. Provider Agreement.** An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)
- 66. Provider Reimbursement Manual.** IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho". (7-1-97)
- 67. 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)
- 68. Quality Improvement Organization (QIO).** An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid beneficiaries. A QIO is formerly known as a Peer Review Organization (PRO). In 42 CFR Chapters I, IV, and V, a "Quality Improvement Organization (QIO)" is replacing "Peer Review Organization (PRO)". (3-20-04)
- 69. 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)
- 70. 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)
- 71. 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)
- 72. Specialized Family Home.** Living situation where a maximum of two (2) waiver participants who do not require a skilled nursing service live with a provider family of residential habilitation services. (3-30-01)
- 73. Speech/Language Pathology and Audiology Services.** Diagnostic, screening, preventative, or corrective services provided by a speech pathologist or audiologist, for which a patient is referred by a physician or other practitioner of the healing arts within the scope of his or her practice under state law. Speech, hearing and

language services do not include equipment needed by the patient such as communication devices or environmental controls. (7-1-99)

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

75. 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)

76. 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)

77. 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)

78. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-30-01)

79. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-01)

80. 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/participants to Title XIX benefits in a NF. (3-30-01)

81. 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 participants. (3-30-01)

82. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-30-01)

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 IDAPA 16.03.09, "Rules Governing the Medical Assistance Program in Idaho," or other MA program information affecting the public can be found on the State web page or will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records" (Confidentiality). Formal requests for specific information can be submitted to the Department's Administrative Procedure Section, 450 W. State Street, P.O. Box 83720, Boise, ID 83720-0036. (3-30-01)

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. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules:

(3-20-04)

01. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at <http://www.sco.state.id.us>. (3-20-04)

02. Medicare Region D Durable Medical Equipment Regional Carrier DMERC Supplier Manual April 2001. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-15-02)

03. Idaho Special Education Manual, September 2001. The full text of the "Idaho Special Education Manual, September 2001" is available on the Internet at <http://www.sde.state.id.us/SpecialEd/manual/sped.asp>. A copy is also available at the Idaho Department of Education, 650 West State Street, P.O. Box 83720, Boise, Idaho 83720-0027. (3-20-04)

04. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at the Department of Health and Welfare at 450 West State Street, P.O. Box 83720, Boise, Idaho 83720-0036. (3-20-04)

05. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (3-20-04)

06. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington,

DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-20-04)

012. (RESERVED).

013. DIAGNOSIS OF BREAST OR CERVICAL CANCER THROUGH THE WOMEN'S HEALTH CHECK.

Women eligible for Medical Assistance, as provided for in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Section 802, will be covered while receiving either primary or adjuvant cancer treatment, or both. The Division of Medicaid, or its successor, is responsible for determining when a woman's treatment has ended. (5-3-03)

01. Primary Treatment. The initial action of treating a patient medically or surgically for cancer using conventional treatment modalities. (5-3-03)

02. Adjuvant Therapy. Treatment that includes either radiation or systemic chemotherapy, or both, as part of the plan of care. (5-3-03)

03. End of Treatment. Cancer treatment ends: (5-3-03)

a. When the woman's plan of care reflects a status of surveillance, follow-up, or maintenance mode; or (5-3-03)

b. If the woman's treatment relies on an unproven procedure, as referred to in Subsection 065.02.h. in these rules, in lieu of primary or adjuvant treatment. (5-3-03)

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 an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) for which a delay in treatment could reasonably be expected by a prudent layperson to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor. (4-5-00)

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)

n. “Prudent layperson” means a person who possesses an average knowledge of health and medicine. (4-5-00)

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 (as defined by the Department for the purpose of payment and performed in an emergency department), dental care (performed in the office), Podiatry (performed in the office), Audiology (hearing tests/screening, does not include ear/nose/throat services), Optical/Ophthalmology/Optomist services (performed in the office), chiropractic (performed in the office), pharmacy (prescription drugs only), nursing home, ICF/MR services, childhood immunizations (not requiring an office visit), flu shots and/or pneumococcal vaccine (not requiring an office visit), diagnosis and/or treatment for sexually transmitted diseases, one screening mammography per calendar year for women age forty (40) or older, and Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services, and in-home services known as Personal Care Services and Personal Care Services Case Management. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers. (4-5-00)

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. Requirement maybe waived by the Department. (7-1-99)

(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; (7-1-99)

(e) Are eligible only as Qualified Medicare Beneficiary; (7-1-99)

(f) Have an existing relationship with a primary care physician or clinic who is not participating with the Healthy Connections; or (7-1-99)

(g) Has incompatible third party liability. (7-1-99)

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 contacting their designated Healthy Connections Representative to do so no later than fifteen (15) days in advance. This advance notice requirement may be waived by the Department. (7-1-99)

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 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. (7-1-99)

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. The health representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (7-1-99)

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 manager of the managed care program 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. (7-1-99)

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 16.05.03, "Contested Case Proceedings and Declaratory Rulings," 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 Sections 226 through 233 of these rules; but (3-30-01)

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 in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (7-1-98)

03. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-01)

a. If payment is requested for transportation costs to receive the out-of-state medical care, the Department or its designee will determine if appropriate, comparable medical care is available closer to the recipient's residence. If such care is available, the Department or its designee will limit authorization to payment for transportation costs associated with a trip to the closer location. If it is determined necessary and appropriate for the medical care to be rendered at the out-of-state location, then the Department or its designee will authorize payment for transportation costs associated with a trip to the out-of-state location. Transportation costs to receive out-of-state medical care requires authorization pursuant to Section 150. (3-30-01)

b. The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the recipient's medical need, or in a temporary situation for a limited period of time required to safely transport the recipient to an Idaho facility. (3-20-04)

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 recipients 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. (7-1-96)

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. (7-1-96)

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". (7-1-96)

03. Definitions. The following terms are applicable to Section 025 of these rules: (7-1-96)

- 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. (7-1-96)
- b.** Equity interest in a home. Any equity interest in real property recognized under Idaho law. (7-1-96)
- 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. (7-1-96)
- 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. (7-1-96)

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)". (7-1-96)

f. Lawfully residing. Residing in a manner not contrary to or forbidden by law, and with the recipient's knowledge and consent. (7-1-96)

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. (7-1-96)

h. Personal property. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. (7-1-96)

i. Real property. Any land, including buildings or immovable objects attached permanently to the land. (7-1-96)

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. (7-1-96)

k. Termination of a lien. The release or dissolution of a lien from property. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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: (7-1-96)

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 (7-1-96)

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 (7-1-96)

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.

(7-1-96)

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: (7-1-96)

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 (7-1-96)

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. (7-1-96)

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. (7-1-96)

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: (7-1-96)

a. The spouse of the recipient; (7-1-96)

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 (7-1-96)

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. (7-1-96)

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: (7-1-96)

a. The recipient has no surviving child who is under age twenty-one (21); (7-1-96)

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 (7-1-96)

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: (7-1-96)

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 (7-1-96)

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. (7-1-96)

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. (7-1-96)

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: (7-1-96)

- a.** The name and last known address of the recipient; and (7-1-96)
- b.** The name and address of the official or agent of the Department filing the lien; and (7-1-96)
- c.** A brief description of the MA received by the recipient; and (7-1-96)
- 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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

14. Estate Recovery. Pursuant to Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: (7-1-96)

- a.** The costs of all MA correctly paid on or after July 1, 1995, on behalf of a recipient who was permanently institutionalized; and (7-1-96)
- 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 (7-1-96)
- 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. (7-1-96)

15. Recovery From Estate of Spouse. If the deceased recipient has no estate, recovery shall be made from the estate of his surviving spouse. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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: (7-1-96)

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. (7-1-96)

b. The deceased recipient's ownership interest in an estate, probated or not probated, is an asset of his estate when: (7-1-96)

i. Documents show the deceased recipient is an eligible devisee or donee of property of another deceased person; or (7-1-96)

ii. The deceased recipient received income from property of another person; or (7-1-96)

iii. State intestacy laws award the deceased recipient a share in the distribution of the property of another estate. (7-1-96)

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. (7-1-96)

d. Life insurance is considered an asset when it has reverted to the estate. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

19. Value of Estate Assets. The Department shall use fair market value as the value of the estate assets. (7-1-96)

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. (7-1-96)

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: (7-1-96)

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. (7-1-96)

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. (7-1-96)

22. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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: (7-1-96)

a. When an undue hardship waiver as defined in Subsection 025.26 of these rules has been granted; or (7-1-96)

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. (7-1-96)

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. (7-1-96)

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. (7-1-96)

28. Basis for Undue Hardship Waiver. Undue hardship waivers shall be considered in the following circumstances: (7-1-96)

a. The estate subject to recovery is the sole income-producing asset of the survivors where such income is limited; or (7-1-96)

b. Payment of the Department's claim would cause heirs of the deceased recipient to be eligible for public assistance; or (7-1-96)

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. (7-1-96)

d. The recipient received MA as the result of a crime committed against the recipient. (7-1-96)

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. (7-1-96)

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. (7-1-96)

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, child birth or disability of an MA recipient. (5-3-03)

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 EPSDT and EPSDT related services. (5-3-03)

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 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 16.05.03, "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 Idaho State Police, 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 16.03.10, Section 456, "Rules Governing Medicaid Provider Reimbursement in Idaho". (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. Section 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, "Eligibility for Health Care Assistance 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 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," the Department or its designee will issue a Medicaid identification card to the eligible person. When requested, the Field Office must give providers of medical services eligibility information regarding those persons. (7-1-98)

02. Identification Card Information. An identification card will be issued to each recipient and will contain the following information: (7-1-98)

- a.** The name of the recipient to whom the card was issued; and (7-1-98)
- b.** The recipient's Medicaid identification number; and (7-1-98)
- c.** The card number. (7-1-98)

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 identification card. (7-1-98)

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 identification card to the admission clerk. The admission clerk will access the Eligibility Verification System (EVS). Where 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 recipients designated as participating in coordinated care by other than the primary care provider, without proper referral, will not be paid. (7-1-98)

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 identification card to the provider, subject to restrictions imposed by a participation in a coordinated care plan. (7-1-98)

b. The provider must obtain the required information by using the Medicaid number on the identification card from the EVS and transfer the required information 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. (7-1-98)

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 must not exceed the Upper Payment limit set forth in the Code of Federal Regulations. (4-6-05)

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 at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (4-6-05)

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, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-30-01)

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a beneficiary is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (5-3-03)

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)

06. Fees for Speech, Occupational and Physical Therapy Services. The fees for physical, occupational, and speech therapy include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (7-1-99)

061. -- 063. (RESERVED).

064. COVERAGE OF INVESTIGATIONAL PROCEDURES OR TREATMENTS.

The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost/benefit analysis on the procedure or treatment in question. The Department will determine coverage based on this review and analysis. (4-7-05)T

01. Focused Case Review. A focused case review consists of assessment of the following: (4-7-05)T

a. Health benefit to the participant of the proposed procedure or treatment; (4-7-05)T

b. Risk to the participant associated with the proposed procedure or treatment; (4-7-05)T

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; (4-7-05)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; (4-7-05)T

e. Phase of the clinical trial of the proposed procedure or treatment; (4-7-05)T

f. Guidance regarding the proposed procedure or treatment by national organizations; (4-7-05)T

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (4-7-05)T

h. Ethics Committee review, if appropriate. (4-7-05)T

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (4-7-05)T

03. Cost/Benefit Analysis. The Department will perform a cost/benefit analysis that will include at

least the following: (4-7-05)T

- a.** Estimated costs of the procedure or treatment in question. (4-7-05)T
- b.** Estimated long-term medical costs if this procedure or treatment is allowed. (4-7-05)T
- c.** Estimated long-term medical costs if this procedure is not allowed. (4-7-05)T
- d.** Potential long-term impacts approval of this procedure or treatment may have on the medical assistance program. (4-7-05)T

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost/benefit analysis, and any additional information received during the review process. (4-7-05)T

065. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE. The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: (4-7-05)T

01. Service Categories Not Covered. The following service categories are not covered for payment by the Medical Assistance Program: (4-7-05)T

- a.** Acupuncture services; (4-7-05)T
- b.** Naturopathic services; (4-7-05)T
- c.** Bio-feedback therapy; and (11-10-87)
- d.** Fertility-related services, including testing. (4-7-05)T

02. Types of Treatments and Procedures Not Covered. The costs of physician and hospital services for the following types of treatments and procedures are not covered for payment by the Medical Assistance Program: (4-7-05)T

- 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; (4-7-05)T
- b.** Cosmetic surgery, excluding reconstructive surgery that has prior approval by the Department; (4-7-05)T
- c.** Acupuncture; (4-7-05)T
- d.** Bio-feedback therapy; (4-7-05)T
- e.** Laetrile therapy; (4-7-05)T
- f.** Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomies; (4-7-05)T
- g.** New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (4-7-05)T
- h.** Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 805; (4-7-05)T

- i.** Examinations: (6-1-86)
 - i.** For routine checkups, other than those associated with the EPSDT program; (4-7-05)T
 - ii.** In connection with the attendance, participation, enrollment, or accomplishment of a program; or (6-1-86)
 - iii.** For employment. (6-1-86)
 - j.** 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; (4-7-05)T
 - k.** The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the Department; (4-7-05)T
 - l.** Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (4-7-05)T
 - m.** Eye exercise therapy; or (4-7-05)T
 - n.** Surgical procedures on the cornea for myopia. (3-2-94)

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Treatments and procedures deemed experimental are not covered for payment by the Medical Assistance Program under the following circumstances: (4-7-05)T

- a.** The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects; (4-7-05)T
- b.** There is inadequate available clinical or pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (4-7-05)T
- c.** Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (4-7-05)T

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. (7-1-98)

067. -- 068. (RESERVED).

069. SURGICAL PROCEDURES FOR WEIGHT LOSS.

01. Surgery for the Correction of Obesity. Surgery for the correction of obesity is covered when all of the following conditions are met: (4-7-05)T

- a.** The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other

affiliation with the surgeons who will perform the surgery. (4-7-05)T

b. The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease. (4-7-05)T

c. The Department or its designee must determine the surgery to be medically necessary, as defined in Section 003 of these rules. (4-7-05)T

d. The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the date a request for prior authorization is submitted to Medicaid. (4-7-05)T

e. The surgery must be prior authorized by the Department or its designee. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized. (4-7-05)T

02. Non-Surgical Treatment for Obesity. Services in connection with non-surgical treatment of obesity are covered only when such services are an integral and necessary part of treatment for another medical condition that is covered by Medicaid. (4-7-05)T

03. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered when medically necessary, as defined in Section 003 of these rules, and when the surgery is prior authorized by the Department or its designee. The request for prior authorization must include the following documentation: (4-7-05)T

a. Photographs of the front, side and underside of the participant's abdomen; (4-7-05)T

b. Treatment of any ulceration and skin infections involving the panniculus; (4-7-05)T

c. Failure of conservative treatment, including weight loss; (4-7-05)T

d. That the panniculus severely inhibits the participant's walking; (4-7-05)T

e. That the participant is unable to wear a garment to hold the panniculus up; and (4-7-05)T

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (4-7-05)T

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 QIO Review. Medicaid will assess the physician a penalty for failure to request a preadmission review from the Department or its designee, for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual, in accordance with Subsection 080.02.a. of these rules and Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho," as amended. If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review the Department will assess a penalty according to Subsection 070.05 entitled "Physician Penalty Chart". The penalty will be assessed after payment for physician services has occurred. (3-20-04)

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

a. A request for preadmission QIO review that is one (1) day late will result in a penalty of fifty dollars (\$50). (3-20-04)

b. A request for preadmission QIO review that is two (2) days late will result in a penalty of one hundred dollars (\$100). (3-20-04)

c. A request for preadmission QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars (\$150). (3-20-04)

d. A request for preadmission QIO review that is four (4) days late will result in a penalty of two hundred dollars (\$200). (3-20-04)

e. A request for preadmission QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars (\$250). (3-20-04)

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 Department will pay the physician for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the physician automatically based upon the Medicare Summary Notice (MSN) information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (5-3-03)

b. If a physician does not accept a Medicare assignment, a Medicare Summary Notice (MSN) must be

attached to the appropriate claim form and submitted to the Department. The Department will pay the physician for the services, up to the Medicaid allowable amount minus the Medicare payment. (5-3-03)

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)

08. Procedure for Locum Tenens Claims and Reciprocal Billing. (3-15-02)

a. In reimbursement for Locum Tenens/Reciprocal Billing, the patient's regular physician may submit the claim and receive payment for covered physician services (including emergency visits and related services) provided by a Locum Tenens physician who is not an employee of the regular physician if: (3-15-02)

- i. The regular physician is unavailable to provide the visit services. (3-15-02)
- ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. (3-15-02)
- iii. The regular physician pays the Locum Tenens for his services on a per diem or similar fee-for-time basis. (3-15-02)

iv. The substitute physician does not provide the visit services to Medicaid patients over a continuous period of longer than ninety (90) days for Locum Tenens and over a continuous period of fourteen (14) days for Reciprocal Billing. (3-15-02)

v. The regular physician identifies the services as substitute physician services meeting the requirements of this Section by appending modifier-Q6 (service furnished by a Locum Tenens physician) to the procedure code or Q5 (services furnished by a substitute physician under Reciprocal Billing arrangements). (3-15-02)

vi. The regular physician must keep on file a record of each service provided by the substitute physician associated with the substitute physician's UPIN, and make this record available to the department upon request. (3-15-02)

vii. The claim identifies (in a manner specified by the department) the physician who furnished the services. (3-15-02)

b. If the only Locum Tenens/Reciprocal billing services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services shall not be reported separately on the claim as substitution services, but shall be deemed as included in the global fee payment. (3-15-02)

c. A physician may have Locum Tenens/reciprocal billing arrangements with more than one (1) physician. The arrangements need not be in writing. Locum Tenens/reciprocal billing services need not be provided in the office of the regular physician. (3-15-02)

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. -- 078. (RESERVED).

079. INPATIENT PSYCHIATRIC HOSPITAL SERVICES.

Pursuant to the philosophy and principles governing children's mental health services in Chapter 24, Title 16, Idaho Code, the Department will pay for medically necessary in-patient psychiatric hospital services in a free standing psychiatric hospital (IMD) or psychiatric unit of a general hospital for recipients under the age of twenty-one (21). Recipients must have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. Admissions must be authorized by the Department or its designee. Failure to request a preadmission or continued stay review in a timely manner will result in a retrospective review being conducted by the Department or its designee. If the retrospective review determines the admission is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 079.11. The primary care physician will be assessed a penalty for failure to request a preadmission review in a timely manner as specified in Subsection 079.12. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the recipient is not subject to this penalty.

(3-30-01)

01. Medical Necessity Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital.

(7-1-99)

a. Severity of illness criteria. The child must meet one (1) of the following criteria related to the severity of his psychiatric illness:

(7-1-99)

i. Is currently dangerous to self as indicated by at least one (1) of the following:

(7-1-99)

(1) Has actually made an attempt to take his own life in the last seventy-two (72) hours (details of the attempt must be documented); or

(7-1-99)

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or

(7-1-99)

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the child or a reliable source and details of the child's plan must be documented); or

(7-1-99)

(4) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm himself and is at significant risk to making an attempt to carry out the plan without immediate intervention (details must be documented); or

(7-1-99)

ii. Child is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others as indicated by one (1) of the following:

(7-1-99)

(1) The child has actually engaged in behavior harmful or potentially harmful to others or caused serious damage to property which would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (7-1-99)

(2) The child has made threats to kill or seriously injure others or to cause serious damage to property which would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (7-1-99)

(3) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-99)

iii. Child is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-99)

(1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (7-1-99)

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or (7-1-99)

(3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication and/or behavior. (7-1-99)

b. Intensity of service criteria. The child must meet all of the following criteria related to the intensity of services needed to treat his mental illness: (7-1-99)

i. It is documented by the Regional Mental Health Authority that less restrictive services in the community do not exist or do not meet the treatment or diagnostic needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried, and/or needed must be documented; and (7-1-99)

ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-99)

iii. Treatment of the child's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be eligible for independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other. (7-1-99)

c. Exceptions. The requirement to meet intensity of service criteria may be waived for first time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the child is in his current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (7-1-99)

02. Exclusions. If a child meets one (1) or more of the following criteria, Medicaid reimbursement under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," will be denied: (3-30-01)

a. The child is unable to actively participate in an outpatient psychiatric treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-99)

b. The child demonstrates anti-social or criminal behavior or has criminal or legal charges against him and does not meet the severity of illness or intensity of service criteria; or (7-1-99)

c. The child has anti-social behaviors or conduct problems that are a danger to others but are not attributable to a mental illness (DSM IV) with substantial impairment in thought, mood or perception; or (7-1-99)

d. The child has a primary diagnosis of mental retardation and the primary treatment need is related to the mental retardation; or (7-1-99)

e. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria; or (7-1-99)

f. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria. (3-30-01)

03. Prior Authorization for Elective Admissions. To qualify for reimbursement, prior authorization must be obtained from the Department or its designee prior to an elective admission. An elective admission is defined as one that is planned and scheduled in advance, and is not emergency in nature, as "emergency" is defined in Subsection 079.04. Requests for prior authorization must include: (3-30-01)

a. Diagnosis; and (7-1-99)

b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (7-1-99)

c. Medical history; and (7-1-99)

d. Mental and physical functional capacity; and (7-1-99)

e. Prognosis; and (7-1-99)

f. Recommendation by a physician for admission, preferably the primary care physician. If the child is enrolled in the Healthy Connection (HC) program, a HC referral is required. (7-1-99)

04. Emergency Admissions. An emergency for purposes of a waiver of the prior authorization requirement is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person. A court-ordered admission or physician's emergency certificate does not, in itself, justify characterizing the admission as an emergency admission. The severity of illness and intensity of services criteria must be met. The hospital medical record of the admission must include documentation to support that the recipient's status upon admission meets the definition of an emergency, as defined in this Section. The information for authorization of services must be FAXED, or otherwise delivered to the Department or its designee on the next business day following the emergency admission. Requests for authorization of emergency admissions must include the same information as required for elective admissions. (3-30-01)

05. Length of Stay. An initial length of stay will be established by the Department or its designee. An initial length of stay will usually be for no longer than five (5) days. For first time admissions where intensity of services criteria is not met the initial length of stay may not exceed forty-eight (48) hours. A hospital may request a continued stay review from the Department or its designee when the appropriate care of the recipient indicates the need for hospital days in excess of the originally approved number. The continued stay review request may be made no later than the date authorized by the Department or its designee. Approval of additional days will be based on the following criteria: (3-30-01)

a. Documentation sufficient to demonstrate the medical necessity criteria is still met; and (3-30-01)

b. A plan of care that includes documentation sufficient to demonstrate that the child's psychiatric condition continues to require services which can only be provided on an in-patient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease; and (3-30-01)

c. Documentation sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the recipient's condition. (3-30-01)

06. Individual Plan of Care. The individual plan of care is a written plan developed for the recipient upon admission to an in-patient psychiatric hospital to improve his condition to the extent that acute psychiatric care is no longer necessary. The plan of care must be developed and implemented within seventy-two (72) hours of admission, reviewed at least every three (3) days, and must: (7-1-99)

a. Be based on a diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the recipient's situation and reflects the need (medical necessity criteria) for in-patient care; and (7-1-99)

b. Be developed by an interdisciplinary team capable of assessing the child's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the child's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: (7-1-99)

i. Board-certified psychiatrist (preferably with a specialty in child psychiatry); or (7-1-99)

ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (7-1-99)

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and (5-3-03)

iv. Either a licensed, clinical or masters social worker or a registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals (preferably children); or (5-3-03)

v. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating mentally ill individuals (preferably children); and (7-1-99)

vi. The recipient and his parents, legal guardians, or others into whose care he will be released after discharge. (7-1-99)

c. State treatment objectives (related to conditions that necessitated the admission); and (7-1-99)

d. Prescribe an integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the child), and experiences designed to meet the objectives; and (7-1-99)

e. Include a discharge and post discharge plan designed to achieve the child's discharge at the earliest possible time and include plans for coordination of community services to ensure continuity of care with the recipient's family, school and community upon discharge. (7-1-99)

07. Provider Qualifications. Inpatient hospital psychiatric services for individuals under age twenty-one (21) must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. Facilities currently providing psychiatric hospital services under the authority of Family and Community Services that are certified by the Health Care Financing Administration have until October 1, 1998 to comply with this requirement. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services to children. General hospitals licensed to provide services in Idaho which are not JCAHO certified may not bill for psychiatric services beyond emergency screening and stabilization (7-1-99)

08. Payment. Reimbursement for the recipient's admission and length of stay is subject to preadmission, concurrent or retrospective review by the Department or its designee. The hospital and the recipient's physician are responsible for obtaining the required review. If such review identifies that an admission or continued

stay is not medically necessary, then no Medicaid payment will be made. (3-30-01)

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lessor of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (7-1-99)

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (7-1-99)

c. The recipient may be charged for services only when he or she has made an informed decision to incur expenses for services deemed not medically necessary by the Department or its designee. (3-30-01)

d. Reimbursement for services originally identified as not medically necessary 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," Section 301, et seq. (3-30-01)

09. Record Keeping. A written report of each evaluation and the plan of care must be entered into the child's record at the time of admission or if the child is already in the facility, immediately upon completion of the evaluation or plan. (7-1-99)

10. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each child's need for the services that the hospital furnishes him. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. (7-1-99)

11. Hospital Penalty Chart. Failure to request a preadmission or continued stay review from the Department or its designee in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission: (3-30-01)

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars (\$260). (3-30-01)

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars (\$520). (3-30-01)

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars (\$780). (3-30-01)

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars (\$1,040). (3-30-01)

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars (\$1,300). (3-30-01)

12. Physician Penalty Chart. Failure to request a preadmission review from the Department or its designee in a timely manner will result in the primary care physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the recipient. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: (3-30-01)

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars (\$50). (3-30-01)

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars (\$100). (3-30-01)

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars (\$150). (3-30-01)

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars (\$200). (3-30-01)

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars (\$250). (3-30-01)

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 Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid 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 QIO review as required by Section 080, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO 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". (3-20-04)

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the recipient's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-20-04)

ii. Reimbursement for services originally identified as not medically necessary by the QIO 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 Case Proceedings and Declaratory Rulings". (3-20-04)

iii. Absent the Medicaid recipient's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the recipient. (3-20-04)

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 Medicaid for the billing of Medicare co-insurance and deductible charges. (3-30-01)

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 QIO. The designated QIO must prepare, distribute and maintain a provider manual, which must be periodically updated. The manual will include, and is not limited to, the following: (3-20-04)

a. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (3-20-04)

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 QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. (3-20-04)

d. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (3-20-04)

e. The procedures which providers or recipients will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days". (3-20-04)

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

a. A request for a preadmission and/or continued stay QIO 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. (3-20-04)

b. A request for a preadmission and/or continued stay QIO 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. (3-20-04)

c. A request for a preadmission and/or continued stay QIO 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. (3-20-04)

d. A request for a preadmission and/or continued stay QIO 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. (3-20-04)

e. A request for a preadmission and/or continued stay QIO 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. (3-20-04)

081. ORGAN TRANSPLANTS.

The Department may reimburse for organ transplant services for bone marrows, kidneys, hearts, intestines, and livers when provided by hospitals approved by the Centers for Medicare and Medicaid for the Medicare program that have completed a provider agreement with the Department. The Department may reimburse for cornea transplants for conditions where such transplants have demonstrated efficacy.(4-7-05)T

01. Kidney Transplants. Kidney transplant 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.(4-7-05)T

02. 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)

03. Intestinal Transplants. Intestinal transplant surgery will be covered only for patients with irreversible intestinal failure, and who have failed total parenteral nutrition.(4-7-05)T

04. Coverage Limitations.(4-7-05)T

a. Multi-organ transplants may be covered when:(4-7-05)T

i. The primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process; and(4-7-05)T

ii. The damage to the second organ will compromise the outcome of the transplant of the primary organ. (4-7-05)T

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

c. 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)

d. A liver transplant from a live donor will not be covered by the Medical Assistance Program; (4-7-05)T

e. No organ transplants covered by the Medical Assistance Program unless prior authorized by the Department or its designee, and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy.(4-7-05)T

05. 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 Department will pay the hospital for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the hospital automatically based upon the Medicare Summary Notice (MSN) cross-over information. (5-3-03)
- c.** For all other services, a Medicare Summary Notice (MSN) must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (5-3-03)
- 03. Preauthorization for Selected Outpatient Procedures.** Failure to obtain a timely review from the Department or its designee prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook as amended for clients who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 080.04 of these rules, when a review is conducted due to an untimely request. (3-20-04)
- 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. -- 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. (3-20-04)

- 02. 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, a licensed physician must certify in writing that, in the physician's 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 (3-20-04)
 - iv.** Documentation that the woman was under the age of eighteen (18) at the time of sexual intercourse. (3-20-04)
 - b.** In the case where the abortion is necessary to save the life of the woman, a licensed physician 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. (3-20-04)

096. -- 100. (RESERVED).

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 dietitian 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, when medically necessary, reasonable, and cost effective, durable medical equipment (DME) and medical supplies for participants residing in community settings including those provided through home health agency plans of care which meet the requirements found in Subsections 105.01 and 105.02. No payment will be made for any participant's DME or medical supplies that are included in the per diem payment while such an individual is an inpatient in a hospital NF, or ICF/MR. The participant has a responsibility to reasonably protect and preserve equipment issued to him. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse/abuse are the responsibility of the participant. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. (3-15-02)

01. Medical Necessity Criteria. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in Durable Medical Equipment Regional Carrier Supplier Manual, hereafter referred to as DMERC. Exceptions to Medicare coverage are contained in this Section of these rules. DME/medical supplies will be purchased or rented only if ordered in writing (signed and dated) by a physician as listed in DMERC. Date of delivery is considered the date of service. The following information to support the medical necessity of the item(s) shall be included in the physician's order and accompany all requests for prior authorization or be kept on file with the DME provider for items which do not require prior authorization: (3-15-02)

a. The participant's medical diagnosis including current information on the medical condition which requires the use of the supplies and/or medical equipment; and (3-15-02)

b. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; and (7-1-99)

c. For medical equipment, a full description of the equipment needed. All modifications or attachments to basic equipment must be supported; and (7-1-99)

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

e. Documentation of the participant's medical necessity for the item, that meets coverage criteria in the DMERC. (3-15-02)

f. Additional information may be requested by the Department or its designee for specific equipment and/or supplies such as, but not limited to, wheelchairs, apnea monitors, oximeters, hospital beds or equipment for which DMERC has established no coverage criteria. (3-15-02)

g. Items for convenience, comfort or cosmetic reasons are not covered. (3-15-02)

02. Medical Equipment Program Requirements. All claims for durable medical equipment are subject to the following guidelines: (7-1-99)

a. Unless specified by the Department, durable medical equipment requires prior authorization by the Department or its designee. (3-15-02)

i. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. Medicaid payment will be denied for the medical item or service or portions thereof which were provided prior to the submission of a valid

prior authorization request. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible pursuant to IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled," Subsection 051.03 and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. (3-15-02)

ii. A valid prior authorization request is a written, faxed, or electronic request from a provider of Medicaid for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. (3-15-02)

b. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (3-15-02)

i. Rental payments, including intermittent payments, shall automatically be applied to the purchase of the equipment. (3-15-02)

ii. The Department may choose to continue to rent certain equipment without purchasing it. Such items include but are not limited to apnea monitor, ventilators and other respiratory equipment. (3-15-02)

iii. The total monthly rental cost of a DME item shall not exceed one-tenth (1/10) of the total purchase price of the item. (7-1-99)

c. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). (3-15-02)

d. No reimbursement will be made for the cost of repairs (materials or labor) covered under the manufacturer's warranty. The date of purchase and warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: (7-1-99)

i. A power drive wheelchair shall have a minimum one (1) year warranty period; (7-1-99)

ii. An ultra light or high strength lightweight wheelchair shall have a lifetime warranty period on the frame and crossbraces; (3-15-02)

iii. All other wheelchairs shall have a minimum one (1) year warranty period; (7-1-99)

iv. All electrical components and new or replacement parts shall have a minimum six (6) month warranty period; (7-1-99)

v. All other DME not specified above shall have a minimum one (1) year warranty period; (7-1-99)

vi. 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)

vii. The monthly rental payment shall include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (3-15-02)

e. Covered equipment must meet the definition of durable medical equipment and be medically necessary as defined in Subsection 003.36. All equipment must be prior authorized by the Department or its designee except for the following: (4-5-00)

i. Bilirubin lights (require prior authorization after fourteen (14) days); and (3-15-02)

- ii. Commode chairs and toilet seat extenders; and (11-1-86)
- iii. Crutches and canes; and (11-1-86)
- iv. Electric or hydraulic patient lift devices designed to transfer a person to and from bed to wheelchair or bathtub, but excluding lift chairs, devices attached to motor vehicles, and wall mounted chairs which lift persons up and down stairs; and (3-15-02)
- v. Grab bars for the bathroom adjacent to the toilet and/or bathtub; and (11-1-86)
- vi. Hand-held showers; and (11-1-86)
- vii. Head gear (protective); and (7-1-99)
- viii. Hearing aids (see Section 108 for coverage and limitations); and (7-1-99)
- ix. Home blood glucose monitoring equipment; and (11-1-86)
- x. Non-implantable intravenous infusion pumps, and/or NG/gastric tube feeding pumps, IV poles/stands, intrathecal administration kits; and (3-15-02)
- xi. Hand-held nebulizers and manual or electric percussor; and (3-15-02)
- xii. Medication organizers; and (7-1-99)
- xiii. Oxygen equipment; and (3-15-02)
- xiv. Compressors and breathing circuits, humidifiers used with IPPB or oxygen; (3-15-02)
- xv. Sliding boards and bath benches/chairs; and (11-1-86)
- xvi. Suction pumps; and (11-1-86)
- xvii. Sheep skins, foam or gel pads or alternating pressure pad with pump for the prevention or treatment of decubitus ulcers; and (3-15-02)
- xviii. Traction equipment; and (7-1-99)
- xix. Walkers. (4-5-00)

03. Coverage Conditions -- Equipment. Medical equipment is subject to coverage limitations in DMERC. Additional documentation requirements or coverage beyond those in the DMERC Supplier Manual include: (3-15-02)

a. Wheelchairs. The Department will provide the least costly wheelchair that is appropriate to meet the participant's medical needs. Wheelchair rental or purchase requires prior authorization by the Department or its designee. (3-15-02)

i. In addition to the physician's information, each request for purchase of a wheelchair must be accompanied by a written evaluation by a physical therapist or an occupational therapist. The evaluation must include documentation of the appropriateness and cost effectiveness of the specific wheelchair and all modifications and/or attachments and its ability to meet the participant's long-term medical needs. For each request for a rental of a wheelchair, a physical therapist or an occupational therapist evaluation may be required on a case-by-case basis, to be determined by the Department or its designee; (3-15-02)

ii. Additional wheelchairs or seating systems may be considered within the five (5) year limitation

with written documentation from the physician and a written evaluation from a physical therapist or an occupational therapist indicating the reason the current wheelchair no longer meets the participant's medical needs and cannot be modified to meet the participant's needs. All documentation required for a wheelchair or seating system purchase is required. (3-15-02)

b. Semi-electric hospital beds must be prior authorized by the Department or its designee and will be approved only when the physician documents that the participant meets the criteria set by DMERC and the participant lives in an independent living situation where there is no one available to provide assistance with a manual bed a major portion of the day. (3-15-02)

c. Communication devices will be considered for purchase by the Department under the following conditions. (3-15-02)

i. The need for the device must be based on a comprehensive history and physical. (4-5-00)

ii. The individual must lack the ability to communicate needs with the primary care physician or caregiver. (3-15-02)

iii. If the individual knows sign language or is capable of learning sign language a communication device would not be considered medically necessary. (3-15-02)

iv. The assessment and evaluation for the communication device must include comprehensive information as related to the individual's ability to communicate and review of the most cost effective devices to meet the individuals needs. Documentation shall include: (4-5-00)

(1) Demographic and biographic summary; (4-5-00)

(2) Inventory of skills and sensory function; (4-5-00)

(3) Inventory of present and anticipated future communication needs; (4-5-00)

(4) Summary of device options; (4-5-00)

(5) Recommendation for device; and (4-5-00)

(6) Copy of individual treatment plan. (4-5-00)

v. Repairs to the device must be prior authorized and must not include modifications, technological improvements or upgrades. (4-5-00)

vi. Reimbursable supplies include rechargeable batteries, overlays, and symbols. (4-5-00)

vii. The use or provision of the system by any individual other than the participant for which the system was authorized is prohibited. (3-15-02)

viii. Training and orientation of the communication device may be billed as speech therapy by Medicaid approved providers such as a Developmental Disability Agency, or a Hospital that employs a speech therapist. (4-5-00)

d. Maternity abdominal supports will be covered if the participant has: (3-15-02)

i. Vulvular varicosities; or (3-15-02)

ii. Perineal edema; or (3-15-02)

iii. Lymphedema; or (3-15-02)

- iv. External prolapse of the uterus or bladder; or (3-15-02)
 - v. Hip separation; or (3-15-02)
 - vi. Pubic symphysis separation; or (3-15-02)
 - vii. Severe abdominal or back strain. (3-15-02)
 - e. Apnea monitors when there is documented apneic episodes in the last two (2) months. (3-15-02)
- 04. Medical Supply Program Requirements.** The Department will purchase no more than a one (1) month supply of necessary medical supplies per calendar month for the treatment or amelioration of a medical condition identified by the attending physician. Limitations for supplies follow DMERC. Supplies in excess of those limitations must be prior authorized by the Department. (3-15-02)
- a. Each request for prior authorization must include all information required in Subsection 106.01. (7-1-99)
 - b. Supplies other than those listed below will require prior authorization: (4-5-00)
 - i. Catheter supplies including catheters, drainage tubes, collection bags, and other incidental supplies; and (11-1-86)
 - ii. Cervical collars; and (11-1-86)
 - iii. Colostomy and/or urostomy supplies; and (11-1-86)
 - iv. Cotton tip applicators; and (3-15-02)
 - v. Disposable supplies necessary to operate Department approved medical equipment such as suction catheters, syringes, saline solution, etc.; and (11-1-86)
 - vi. Dressings and bandages to treat wounds, burns, or provide support to a body part; and (11-1-86)
 - vii. Fluids for irrigation; and (11-1-86)
 - viii. Incontinence supplies (See Subsection 106.05.b. for limitations); and (7-1-99)
 - ix. Injectable supplies including normal saline and Heparin but excluding all other prescription drug items; and (10-31-89)
 - x. Blood glucose or urine glucose checking/monitoring materials (tablets, tapes, strips, etc.), lancets; and (3-15-02)
 - xi. Therapeutic drug level home monitoring kits. (10-31-89)
 - xii. Oral, enteral, or parenteral nutritional products, see Subsection 106.05.a. additional documentation requirements. (3-15-02)
- 05. Coverage Conditions -- Supplies.** Medical supplies are covered when medical necessity criteria per the Medicare DMERC Supplier Manual or the following medical supply items are subject to the following limitations and additional documentation requirements: (3-15-02)
- a. Nutritional products. Nutritional products will be purchased for participants who meet DMERC criteria, when the supplement is given by tube feeding or orally to meet caloric needs of the participant who cannot maintain growth, weight, and strength commensurate with his general condition from traditional foods alone. (3-15-02)

i. A nutritional plan shall be developed and be on file with the provider 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 must be included; (7-1-99)

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 as needed but at least annually. (7-1-99)

b. Incontinent supplies. Incontinent supplies are covered for persons over four (4) years of age only and do not require prior authorization unless the participant needs supplies in excess of the following limitations: (3-15-02)

i. Diapers are restricted in number to two hundred forty (240) per month. If the physician documents that additional diapers are medically necessary, the Department or its designee may authorize additional amounts on an individual basis. (7-1-99)

ii. Disposable underpads are restricted to one hundred fifty (150) per month. (10-22-93)

iii. Pullups are only allowed when the participant is participating in a formal toilet training program written by an Occupational Therapist, QMRP or Developmental Specialist. Documentation for toilet training program must be updated on a yearly basis. (3-15-02)

06. Program Abuse. The use or provision of DME/medical supply items to an individual other than the participant for which such items were ordered is prohibited. The provision of DME/medical supply items that is not supported by required medical necessity documentation is prohibited and subject to recoupment. 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. Participants suspected of the same shall be reported to the SUR/S committee. (3-15-02)

07. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department or its designee is required, the authorization number must be included on the claim form. (7-1-99)

08. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04 Individual Provider Fees. (12-31-91)

09. Date of Service. Unless specifically authorized by the Department or its designee the date of services for durable medical equipment and supplies is the date of delivery of the equipment and/or supply(s). The date of service cannot be prior to the vendor receiving all medical necessity documentation. (7-1-99)

10. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has thirty (30) days from the date of the denial to request an administrative hearing on the decision. Hearings will be conducted to IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 300, and IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (3-15-02)

107. OXYGEN AND RELATED EQUIPMENT.

Medicaid will provide payment for oxygen and oxygen-related equipment based upon the Department's fee schedule. Such services are considered reasonable and necessary only for participants with significant hypoxemia and certain related conditions. In addition, providers must be eligible for Medicare program participation prior to the issuance of a Medicaid provider number. (3-15-02)

01. Medical Necessity Documentation. Oxygen and related equipment are provided only upon the

written order of a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier Manual, with the following exceptions: (3-15-02)

a. A diagnosis of cluster headaches which has not responded to medications and there is documentation of successful treatment on a trial basis in the emergency room or physician's office. (7-1-99)

b. Lab studies are not required for recipients age zero (0) to six (6) months. (7-1-99)

02. Prior Authorization. Prior authorization for oxygen is required by the Department or its designee for the following: (7-1-99)

a. Participants age seven (7) months to twenty (20) years of age if there is a physician's order but lab study requirements are not met. (3-15-02)

b. When the diagnosis is cluster headaches. (3-15-02)

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 participants are eligible for audiometric examination and testing once in each calendar year. Basic audiometric testing by certified audiologists or licensed physicians will be covered without prior approval. (3-15-02)

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done and kept on file by the provider. (7-1-99)

03. Hearing Aids. The Department will cover the purchase of one (1) hearing aid per participant per lifetime with the following requirements and limitations: (3-15-02)

a. The following information must be documented and kept on file with the provider: the participant's diagnosis, 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. (3-15-02)

b. 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)

c. The following services may be covered in addition to the purchase of the hearing aid: 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. (7-1-99)

d. Lost, misplaced, stolen or destroyed hearing aids shall be the responsibility of the participant. 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. (3-15-02)

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 participant if a properly completed claim is submitted to the Department within the one (1) year billing limitation. (3-15-02)

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 most cost-effective type and model which meets the participant's medical needs. (3-15-02)

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 participants for charges in excess of the fees allowed by the Department for materials and services. (3-15-02)

e. Audiology services will be a benefit for EPSDT eligible participants under the age of twenty-one (21) (See Section 100). (3-15-02)

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 at 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)

03. Mammography Services. Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment and staff which is considered certifiable or certified by the Bureau of Laboratories. (7-1-98)

a. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age. (7-1-99)

b. Diagnostic mammographies will be covered when a physician orders the procedure for a patient of

any age who is at high risk.

(7-1-98)

111. -- 117. (RESERVED).

118. DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.

The Department will purchase service coordination services for Medicaid-eligible participants with developmental disabilities when authorized through the Department's prior authorization process in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," and provided by an organized service coordination provider agency who has entered into a written provider agreement with the Department. The purpose of these services, as described in IDAPA 16.03.17, "Service Coordination," is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services.

(4-6-05)

119. (RESERVED).

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES AGENCIES.

Under 42 CFR 440.130(d), the Department will pay for rehabilitative services including medical or remedial services provided by facilities that have entered into a provider agreement with the Department and are licensed as developmental disabilities agencies by the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements.

(3-20-04)

01. Requirement for Plan of Service and Prior Authorization. All services for adults with developmental disabilities and ISSH waiver participants must be identified on the plan of service and prior authorized as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," Sections 200 through 320.

(3-20-04)

02. Individual Program Plan Requirement. All services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies".

(3-20-04)

03. Evaluation and Diagnostic Services. Medical/social, psychological, speech and hearing, physical, developmental, and occupational therapy evaluations must meet the requirements of IDAPA 16.04.11, "Developmental Disabilities Agencies". Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid.

(3-20-04)

04. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies". The therapy services listed in Subsections 120.04.a. through 120.04.f. of this rule may be prior authorized for up to thirty (30) hours per week. These therapy services in combination with community supported employment services must not be authorized for more than forty (40) hours per week. Covered treatment services include the following therapies:

(3-20-04)

a. Developmental Therapy. Developmental therapy may be delivered in a Developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy.

(3-20-04)

b. Psychotherapy Services. Psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year, and include:

(3-20-04)

i. Individual psychotherapy;

(7-1-95)

- ii. Group psychotherapy; and (3-20-04)
- iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-20-04)
- c. Speech and Hearing Therapy Services. Speech and hearing therapy services are limited to two hundred fifty (250) treatment sessions per calendar year. Speech and hearing therapy includes individual or group therapy. (3-20-04)
- d. Physical Therapy. Physical therapy services are limited in accordance with Section 140 of these rules. Physical therapy includes individual or group therapy. (3-20-04)
- e. Occupational Therapy. Occupational therapy includes individual occupational therapy and group occupational therapy. Developmental and occupational therapy services alone or in combination are limited to a maximum of thirty (30) hours per week. (3-20-04)
- f. Intensive Behavioral Intervention (IBI). Intensive behavioral intervention includes individual intensive behavioral intervention and intensive behavioral intervention consultation. (3-20-04)
- g. Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (3-20-04)
- h. Except in the case of a child prior authorized for additional therapy hours through the EPSDT program, the services of developmental therapy, occupational therapy, and intensive behavioral intervention are limited to no more than thirty (30) hours per week either alone or in combination. (3-20-04)
- i. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (3-20-04)
- 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 agency services must be in accordance with rates established by the Department. (3-30-01)
 - a. Providers of services must accept as payment in full the Department's payment for such services and must not bill a Medicaid participant for any portion of any charges. (3-20-04)
 - 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 participant. Proof of billing other third party payors is required. (3-20-04)
- 121. AMBULATORY SURGICAL CENTER.**
The Department must provide Ambulatory Surgical Centers (ASC) services for eligible participants. (3-20-04)
 - 01. Facility Approval.** The ASC must be surveyed by the Department's Bureau of Facility Standards 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. (3-20-04)

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 include: (3-20-04)

- a. The loss of Medicare program approval; (3-20-04)
- b. Identification of any condition which threatens the health or safety of patients by the Department's Bureau of Facility Standards. (3-20-04)

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 list 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). (3-20-04)

- 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 of this rule, but which is not covered by Medicare will have a reimbursement rate established by the Department. (3-20-04)

- b. ASC facility services include the following: (3-20-04)
 - i. Nursing, technician, and related services; (3-20-04)
 - ii. Use of ASC facilities; (3-20-04)
 - iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (3-20-04)
 - iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (3-20-04)
 - 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; (3-20-04)
 - ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (3-20-04)
 - iii. Prosthetic and orthotic devices; (3-20-04)
 - iv. Ambulance services; (3-20-04)
 - 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. of this rule. (3-20-04)

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. See Section 100 for additional guidelines for recipients under the age of twenty one (21). (7-1-99)

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. (7-1-99)

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. (7-1-99)

a. Polycarbonate lenses will be purchased only when there is clear documented evidence that the thickness of the plastic lenses precludes their use (prescriptions above plus or minus two (2) diopters of correction). Documentation must be kept on file by both the examining and supplying providers. (7-1-99)

b. Scratch resistant coating is required for all plastic and polycarbonate lenses. (7-1-98)

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 as defined in the Medical Vendor Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. (7-1-99)

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. Prior authorization is required by the Department or its designee. (7-1-99)

03. Replacement Lenses. Replacement lenses will be purchased prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Medical Vendors Provider Handbook. (7-1-99)

04. Frames. Frames will be purchased according to the following guidelines: (7-1-99)

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. (7-1-98)

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. (7-1-98)

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. The following information must be included in the physicians order and must be kept on file by the provider: (7-1-99)

- 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)

02. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services purchased by the Department: (7-1-99)

- a.** A temporary lower limb prosthesis shall be purchased 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; (7-1-99)
- 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.** 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 or its designee for consideration; (7-1-99)
- g.** 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. (7-1-99)

e. Electronically powered or enhanced prosthetic devices are not covered by the program; (10-1-91)

f. The Department or its designee 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; (7-1-99)

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. (7-1-99)

05. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04. (12-31-91)

125. -- 127. (RESERVED).

128. DIABETES EDUCATION AND TRAINING SERVICES.

01. Education and Training Conditions. Outpatient diabetes education and training services will be covered under the following conditions: (7-1-98)

a. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association. (7-1-98)

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. (7-1-98)

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. (7-1-98)

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. (7-1-98)

03. Diabetes Counseling. To receive diabetes counseling, the following conditions apply to each patient: (7-1-98)

a. The patient must have written order by his or her primary care physician or physician extender referring the patient to the program. (7-1-98)

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. (7-1-98)

c. The medical necessity for diabetes education and training are evidenced by the following: (7-1-98)

i. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (7-1-98)

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 (7-1-98)

iii. Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (7-1-98)

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. (7-1-98)

04. Reimbursement. Diabetes education and training services will be reimbursed according to the Department's established fee schedule. (7-1-98)

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 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. (7-1-98)

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. 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 twenty-four (24) manipulation visits during any calendar year for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition.

(3-15-02)

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.

(7-1-96)

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.

(7-1-96)

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.

(7-1-96)

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. HCPCS code G0169 is also covered. 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.

(3-30-01)

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.

(7-1-96)

d. The equipment used by the physical therapists to provide services is up to the discretion of the therapist and physician. All therapeutic equipment used by the therapist is included in the fee for service payment and no separate charge may be made to either the Medicaid program or client.

(7-1-99)

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 and patients with chronic conditions which require on-going physical therapy. 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. Individuals with chronic medical conditions, as documented by physician, may be reordered up to every six (6) months. 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.

(7-1-99)

03. Payment Procedures. Payment procedures are as follows: (7-1-96)

a. Each recipient is limited to twenty-five (25) visits of outpatient physical therapy during any calendar year. The Department may authorize additional visits if such services are determined to be medically necessary. Visits to outpatient departments of hospitals and services provided by school districts, developmental disability agencies, or independent physical therapists providing physical therapy are included in the limit on the total outpatient physical therapy visits. (3-30-01)

b. 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. Physical therapy provided by home health agencies will be paid at a rate per visit as described in Section 105 and subject to the home health visit limitations contained in Section 105.01.c. (3-30-01)

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. (7-1-96)

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 Developmental Disability Agency 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. (3-30-01)

04. Excluded Services. Services excluded from Medicaid program coverage include, group exercise therapy, group hydrotherapy, and biofeedback services. (7-1-99)

141. DEFINITIONS FOR SELF-DIRECTED COMMUNITY SUPPORTS (SDCS) OPTION.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. (7-1-06)T

02. Community Support Worker (CSW). An individual, agency, or vendor selected and paid by the participant to provide Community Support Worker Services. (7-1-06)T

03. Community Support Worker Services. Community Support Worker Services are those identified supports listed in Subsection 142.02.c. of these rules. (7-1-06)T

04. Guiding Principles for the SDCS Option. Self-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (7-1-06)T

a. Freedom for the participant to make choices and plan his own life; (7-1-06)T

b. Authority for the participant to control resources allocated to him to acquire needed supports; (7-1-06)T

c. Opportunity for the participant to choose his own supports; (7-1-06)T

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (7-1-06)T

e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (7-1-06)T

05. Financial Management Services (FMS). Services provided by a Fiscal Employer Agent that include: (7-1-06)T

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (7-1-06)T

b. Performing payroll services; and (7-1-06)T

c. Handling billing and employment related documentation responsibilities. (7-1-06)T

06. Fiscal Employer Agent. An agency that provides Financial Management Services (FMS) to participants who have chosen the SDCS option. (7-1-06)T

07. Supports. Refers to services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a Community Support Worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (7-1-06)T

08. Support Broker. An individual who advocates on behalf of the participant and who is hired by the participant to provide Support Broker Services. (7-1-06)T

09. Support Broker Services. Services provided by a Support Broker to assist the participant with planning, negotiating, and budgeting. (7-1-06)T

142. SELF-DIRECTED COMMUNITY SUPPORTS (SDCS) OPTION.

Self-Directed Community Supports (SDCS) is a flexible program option for participants eligible for the Home and Community Based Services - Developmental Disabilities (HCBS-DD) waiver. The SDCS option allows the eligible participant to: choose the type and frequency of supports he wants, negotiate the rate of payment, and hire the person or agency he prefers to provide those supports. The SDCS option requires the participant to have a Support Broker to assist the participant to make informed choices, participate in a person-centered planning process, and become skilled at managing his own supports. The participant must use a Fiscal Employer Agent to provide Financial Management Services (FMS) for payroll and reporting functions. (7-1-06)T

01. Eligibility. (7-1-06)T

a. In order to choose the SDCS option, the participant must first be determined Medicaid-eligible and must be determined to meet existing (HCBS-DD) waiver program requirements as outlined in Section 143 of these rules. (7-1-06)T

b. The participant, and his legal representative, if one exists, must agree in writing using a Department-approved form to the following: (7-1-06)T

i. Accept the guiding principles for the SDCS option, as defined in Section 141 of these rules; (7-1-06)T

ii. Agree to meet the participant responsibilities outlined in Subsection 142.03 of these rules; (7-1-06)T

iii. Take responsibility for and accept potential risks and any resulting consequence for their support choices. (7-1-06)T

c. The participant's legal representative must agree in writing to honor the choices of the participant as required by the guiding principles for the SDCS option. (7-1-06)T

02. Paid Self-Directed Community Supports. The participant must purchase Financial Management Services and Support Broker Services to participate in the SDCS option. The participant must purchase goods and community supports through the Fiscal Employer Agent. (7-1-06)T

a. The Department will contract with a Fiscal Employer Agent, as defined in Section 141 of these rules, to provide Financial Management Services to a participant who chooses the self-directed option. (7-1-06)T

b. Support Broker Services are provided by a trained Support Broker. (7-1-06)T

c. The Community Support Worker provides identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified Community Support Worker must meet the applicable licensing or certification requirements. Identified supports include activities that address the participant's preference for: (7-1-06)T

i. Job support to help the participant secure and maintain employment or attain job advancement; (7-1-06)T

ii. Personal support to help the participant maintain health, safety, and basic quality of life; (7-1-06)T

iii. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community; (7-1-06)T

iv. Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors; (7-1-06)T

v. Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals; (7-1-06)T

vi. Transportation support to help the participant accomplish his identified goals; and (7-1-06)T

vii. Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence. (7-1-06)T

03. Participant Responsibilities. With the assistance of the Support Broker or the legal representative, if one exists, the participant is responsible for the following: (7-1-06)T

a. Accepting and honoring the guiding principles for the SDCS option found in Section 141 of these rules; (7-1-06)T

b. Participating in the person-centered planning process in order to identify and document support and service needs, wants, and preferences; (7-1-06)T

c. Negotiating payment rates for all paid community supports he wants to purchase and including the details in the employment agreements; (7-1-06)T

d. Completing and implementing agreements for the Fiscal Employer Agent, the Support Broker and Community Support Workers and submitting the agreements to the Fiscal Employer Agent. These agreements must be submitted on Department-approved forms; (7-1-06)T

e. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. Ensuring each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the

participant; and no employer-related claims will be filed against the Department; (7-1-06)T

f. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning; (7-1-06)T

g. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice; and (7-1-06)T

h. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers; (7-1-06)T

04. Fiscal Employer Agent Requirements and Limitations. (7-1-06)T

a. The Fiscal Employer Agent must meet the requirements outlined in its contract with the Department. (7-1-06)T

b. The Fiscal Employer Agent must not: (7-1-06)T

i. Provide any other direct services to the participant, to ensure there is no conflict of interest, and; (7-1-06)T

ii. Employ the guardian, parent, spouse, payee or conservator of the participant or have direct control over the participant's choice. (7-1-06)T

05. Fiscal Employer Agent Duties and Responsibilities. The Fiscal Employer Agent performs Financial Management Services for each participant. Prior to providing Financial Management Services the participant and the Fiscal Employer Agent must enter into a written agreement. Financial Management Services services include: (7-1-06)T

a. Providing payroll and accounting supports to participants that have chosen the Self-Directed Community Supports option; (7-1-06)T

b. Performing financial reporting for employees of each participant; (7-1-06)T

c. Preparing and distributing a packet of information, including Department-approved forms for agreements, for the participant hiring his own staff; (7-1-06)T

d. Processing and paying time sheets for Community Support Workers and Support Brokers, as authorized by the participant, according to the participant's Department-authorized support and spending plan; (7-1-06)T

e. Managing and processing payment of required state and federal employment taxes for the participant's Community Support Workers and Support Brokers; (7-1-06)T

f. Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's support and spending plan; (7-1-06)T

g. Providing each participant with reporting information that will assist the participant with managing the individualized budget; and (7-1-06)T

h. Participating in Department quality assurance activities. (7-1-06)T

06. Support Broker Requirements and Limitations. (7-1-06)T

a. A Support Broker must complete the Department-approved Support Broker training and certification process prior to providing any paid services to the participant. To enroll in Support Broker training, the Support Broker must provide documentation to the Department that he: (7-1-06)T

- i. Is eighteen (18) years of age or older; (7-1-06)T
- ii. Has skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and (7-1-06)T
- iii. Has at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field. (7-1-06)T
- b.** The Support Broker must not: (7-1-06)T
 - i. Be employed by an agency that provides paid community supports under Subsection 142.02.c. of these rules to the same participant; and (7-1-06)T
 - ii. Be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant's choices. Additionally, the Support Broker must not be in a position to both influence a participant's decision making and benefit financially from the participant's decisions. (7-1-06)T
- 07. Support Broker Duties and Responsibilities.** (7-1-06)T
 - a.** Prior to beginning employment for the participant, the Support Broker must complete the packet of information provided by the Fiscal Employer Agent and submit it to the Fiscal Employer Agent. This packet must include documentation of: (7-1-06)T
 - i. Successful completion of the required Support Broker training; (7-1-06)T
 - ii. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; and (7-1-06)T
 - iii. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the Support Broker. The employment agreement must include the fixed hourly rate for the Support Broker, and the type, frequency, and duration of services. (7-1-06)T
 - b.** Support Broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the Support Broker must: (7-1-06)T
 - i. Participate in the person-centered planning process; (7-1-06)T
 - ii. Develop a written support and spending plan with the participant that includes the supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; (7-1-06)T
 - iii. Assist the participant to monitor and review his budget; (7-1-06)T
 - iv. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (7-1-06)T
 - v. Participate with Department quality assurance measures, as requested; and (7-1-06)T
 - vi. Assist the participant to complete the annual re-determination process as needed, including assisting the participant or his chosen representative to update the support and spending plan and submit it to the Department for authorization. (7-1-06)T
 - c.** Depending on the requests and needs of each participant, the Support Broker may: (7-1-06)T

- i. Assist the participant to develop and maintain a circle of support; (7-1-06)T
- ii. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (7-1-06)T
- iii. Assist the participant to negotiate rates for paid Community Support Workers; (7-1-06)T
- iv. Maintain documentation of supports provided by each Community Support Worker and participant's satisfaction with these supports; (7-1-06)T
- v. Assist the participant to monitor community supports; (7-1-06)T
- vi. Assist the participant to resolve employment-related problems; and (7-1-06)T
- vii. Assist the participant to identify and develop community resources to meet specific needs. (7-1-06)T

d. If a Support Broker decides to end services with a participant, he must give the participant at least fifteen (15) days written notice prior to terminating services. The Support Broker must assist the participant with identifying a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (7-1-06)T

08. Community Support Worker Limitations. A paid Community Support Worker must not have direct control over the participant's choices, must avoid any conflict of interest, and cannot benefit financially from the participant's choices. (7-1-06)T

09. Paid Community Support Worker Duties and Responsibilities. (7-1-06)T

a. Prior to providing goods or services to the participant, the Community Support Worker must complete the packet of information provided by the Fiscal Employer Agent and submit it to the Fiscal Employer Agent. When the Community Support Worker will be providing services, this packet must include documentation of: (7-1-06)T

i. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks" or documentation that this requirement has been waived by the participant. This documentation will include the rationale for waiving the criminal history check and describe how health and safety will be assured in lieu of a completed criminal history check; (7-1-06)T

ii. A completed employment agreement with the participant that specifically defines the type of support being purchased, the negotiated rate, and the frequency and duration of the support to be provided. If the Community Support Worker is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility, if any, for tax related obligations; (7-1-06)T

iii. Current state licensure or certification if identified support requires certification or licensure; and (7-1-06)T

iv. A statement of qualifications to provide supports identified in the employment agreement. (7-1-06)T

b. The Community Support Worker must deliver supports as defined in the employment agreement. (7-1-06)T

c. The Community Support Worker must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's Fiscal Employer Agent or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's Fiscal Employer Agent. (7-1-06)T

d. The Community Support Worker must obtain the signature of the participant or his legal representative on each completed timesheet or invoice prior to submitting the document to the Fiscal Employer Agent for payment. Time sheets or invoices that are not signed by the Community Support Worker and the participant or his legal representative will not be paid. (7-1-06)T

10. Support and Spending Plan Development. (7-1-06)T

a. The participant, with the help of his Support Broker, must develop a comprehensive support and spending plan based on the information gathered during the person centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (7-1-06)T

i. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community; (7-1-06)T

ii. Paid or non-paid self-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-06)T

(1) Personal health and safety including quality of life preferences; (7-1-06)T

(2) Securing and maintaining employment; (7-1-06)T

(3) Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (7-1-06)T

(4) Learning and practicing ways to recognize and minimize interfering behaviors; and (7-1-06)T

(5) Learning new skills or improving existing ones to accomplish set goals. (7-1-06)T

iii. Support needs such as: (7-1-06)T

(1) Medical care and medicine, (7-1-06)T

(2) Skilled care including therapies or nursing needs, (7-1-06)T

(3) Community involvement, (7-1-06)T

(4) Preferred living arrangements including possible roommate(s), and (7-1-06)T

(5) Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any; (7-1-06)T

iv. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (7-1-06)T

v. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; and (7-1-06)T

vi. The budgeted amounts planned in relation to the participant's needed supports. Community Support Worker employment agreements submitted to the Fiscal Employer Agent must identify the negotiated rates agreed upon with each Community Support Worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The Fiscal Employer Agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment. (7-1-06)T

b. Support and spending plan limitations include: (7-1-06)T

i. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the SDCS option; (7-1-06)T

ii. Paid community supports must not be provided in a congregate setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services; (7-1-06)T

iii. All paid community supports must fit into one (1) or more types of community supports described in Subsection 142.02 of these rules. Community supports that are not medically necessary or that do not minimize the participant's need for institutionalization must only be listed as non-paid supports. Additionally, the support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant or do harm, or that violate or infringe on the rights of others; (7-1-06)T

iv. Support and spending plans that exceed the approved budget amount will not be authorized; and (7-1-06)T

v. Time sheets or invoices that are submitted to the Fiscal Employer Agent for payment that exceed the authorized support and spending plan amount will not be paid by the Fiscal Employer Agent. (7-1-06)T

11. Person-Centered Planning. (7-1-06)T

a. The participant agrees to participate in the person-centered planning process in order to identify and document his support and service needs, wants, and preferences. (7-1-06)T

b. The participant decides who he wants to participate in the planning sessions in order to ensure the participant's choices are honored and promoted. (7-1-06)T

c. The participant may direct his person-centered planning meetings, or these meetings may be facilitated by the chosen support broker. (7-1-06)T

d. The person-centered planning should focus on identifying strengths, capacities, preferences, needs, and desired goals of the participant for all life areas. (7-1-06)T

e. The person-centered planning should be completed as timely as possible in order to provide the necessary information required to develop the participant's support and spending plan. Time limitations are not currently mandated in order to allow for extensive, comprehensive planning and thoughtful support and spending plan development. (7-1-06)T

12. Circle of Supports. The circle of support is a means of natural supports for the participant and consists of people who encourage and care about the participant. Work or duties the circle of supports perform on behalf of the participant are not paid. (7-1-06)T

a. The participant's circle of support should be built and operate with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop a plan of action, along with and on behalf of the participant, to help the participant accomplish his personal goals. (7-1-06)T

b. A circle of support may include family members, friends, neighbors, co-workers, and other community members. (7-1-06)T

c. Members of the circle of support are selected by the participant and commit to work within the group to: (7-1-06)T

i. Help promote and improve the life of the participant in accordance with the participant's choices and preferences; and (7-1-06)T

ii. Meet on a regular basis to assist the participant to accomplish his expressed goals. (7-1-06)T

d. A natural support may perform any duty of the Support Broker as long as the Support Broker still completes the required responsibilities listed in Subsection 142.07.b. of these rules. Additionally, any Community Support Worker task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's support plan, but time worked does not need to be recorded or reported to the Fiscal Employer Agent. (7-1-06)T

13. Individualized Budget. The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that he understands the budget figure is a fixed amount. Participants will not be required to accept an individualized budget that is less than the budget of their previous plan year in order to participate in the SDCS option. (7-1-06)T

a. The Department notifies each participant of his set budget amount. The notification will include how the participant may request reconsideration of the set budget amount. (7-1-06)T

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. (7-1-06)T

14. Quality Assurance. The Department will implement quality assurance processes to assure: access to self-directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. (7-1-06)T

a. Each participant will have the opportunity to provide feedback to the Department about his satisfaction with self-directed services utilizing the Participant Experience Survey (PES). (7-1-06)T

b. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (7-1-06)T

i. Access to care; (7-1-06)T

ii. Choice and control; (7-1-06)T

iii. Respect and dignity; (7-1-06)T

iv. Community integration; and (7-1-06)T

v. Inclusion. (7-1-06)T

c. The Fiscal Employer Agent must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, and timely reporting of accounting and satisfaction data. (7-1-06)T

d. Community Support Workers and Support Brokers must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, and spot audits of time sheets and billing records. (7-1-06)T

e. Paid Community Support Workers must be selected by the participant, or his chosen representative, and must meet the qualifications identified in Section 142 of this rule. (7-1-06)T

f. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (7-1-06)T

g. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (7-1-06)T

15. Continuation of the Self-Directed Community Supports (SDCS) Option. The Department may choose not to allow the participant to continue in the SDCS option if the following requirements are not met: (7-1-06)T

- a.** The participant's willingness to work with a Support Broker and a Fiscal Employer Agent; (7-1-06)T
- b.** The participant's support and spending plan is being followed; (7-1-06)T
- c.** Back-up plans to manage risks and safety are being followed; and (7-1-06)T
- d.** The participant's choices do not directly endanger his health, welfare and safety or endanger or harm others. (7-1-06)T

143. WAIVER SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES AND ISSH WAIVER PARTICIPANTS.

Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is 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. (3-20-04)

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 participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-20-04)

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 participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in

nature); (3-20-04)

(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 participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-20-04)

iii. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-20-04)

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 participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party 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 participant. (3-20-04)

c. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-20-04)

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 or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-20-04)

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 participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-20-04)

e. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-20-04)

f. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.

(3-20-04)

g. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation.

(3-20-04)

h. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant 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 participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision.

(3-20-04)

i. Home delivered meals which are designed to promote adequate waiver participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time.

(3-20-04)

j. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

(3-20-04)

k. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis.

(3-20-04)

l. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI.

(3-20-04)

i. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies".

(4-5-00)

ii. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11,

“Developmental Disabilities Agencies”. (4-5-00)

02. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-20-04)

- a.** Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-95)
- b.** Licensed Intermediate Care Facility for persons with Mental Retardation (ICF/MR); and (3-20-04)
- c.** Residential Care or Assisted Living Facility. (3-20-04)
- d.** Additional limitations to specific services are listed under that service definition. (7-1-95)

03. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in IDAPA 16.03.13, “Prior Authorization of Behavioral Health Services,” Sections 200 through 320. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (3-20-04)

04. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-20-04)

05. Provider Qualifications. All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-20-04)

a. Residential habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, “Rules Governing Residential Habilitation Agencies,” and is capable of supervising the direct services provided. Individuals who provide twenty-four (24) hour services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-20-04)

- i.** Direct service staff must meet the following minimum qualifications: (3-20-04)
 - (1) Be at least eighteen (18) years of age; (3-20-04)
 - (2) Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-20-04)
 - (3) Have current CPR and First Aid certifications; be free from communicable diseases; (3-20-04)
 - (4) Satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, “Rules Governing Mandatory Criminal History Checks”. When residential habilitation services are provided in a certified family home, all individuals eighteen (18) years of age or older living in the home must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06; (3-20-04)
 - (5) 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 an agency prior to performing services; and (3-20-04)
 - (6) Have appropriate certification or licensure if required to perform tasks which require certification

or licensure. (3-20-04)

ii. The provider agency will be responsible for providing training specific to the needs of the participant. Skill training must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. Additional training requirements must include at a minimum: (3-20-04)

- (1) Instructional technology; (4-5-00)
- (2) Behavior technology; (4-5-00)
- (3) Feeding; (4-5-00)
- (4) Communication/sign language; (4-5-00)
- (5) Mobility; (4-5-00)
- (6) Assistance with medications (training in assistance with medications must be provided by a licensed nurse); (4-5-00)
- (7) Activities of daily living; (4-5-00)
- (8) Body mechanics and lifting techniques; (4-5-00)
- (9) Housekeeping techniques; and (4-5-00)
- (10) Maintenance of a clean, safe, and healthy environment. (4-5-00)

iii. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes". Non-compliance with the certification process is cause for termination of the provider's provider agreement. (3-20-04)

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 a plan of service. (3-20-04)

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 or must be an individual selected by the waiver participant and/or the family or guardian; (3-20-04)

ii. Have received caregiving instructions in the needs of the person who will be provided the service; (3-20-04)

iii. Demonstrate the ability to provide services according to an plan of service; (3-20-04)

iv. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-20-04)

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 accessibility adaptations services must: (3-20-04)

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. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-20-04)

h. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-20-04)

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; (3-20-04)

ii. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-20-04)

iii. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-20-04)

iv. Provide documentation of current driver's license for each driver; and (7-1-95)

v. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-95)

j. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-20-04)

k. 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 (QMRP). (3-20-04)
- v. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies". (3-20-04)

I. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided to a single participant in a certified family home other than the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (3-20-04)

- i. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (4-5-00)
- ii. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-20-04)
- iii. Be free from communicable disease; (4-5-00)
- iv. Satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; (3-20-04)
- v. Demonstrate knowledge of infection control methods; and (4-5-00)
- vi. Agree to practice confidentiality in handling situations that involve waiver participants. (4-5-00)

06. Participant Eligibility Determination. Waiver eligibility will be determined by the Department as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". The participant must be financially eligible for MA as described in IDAPA 16.03.05, Section 787, "Rules Governing Eligibility for Aid 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 participants must meet the following requirements: (3-20-04)

- a.** DD waiver participants must be eighteen (18) years of age or older. ISSH waiver participants must be fifteen (15) years of age through the month of their eighteenth birthday. (3-20-04)
- b.** The Department or its designee must determine that: (3-20-04)
 - i. The participant would qualify for ICF/MR level of care as set forth in Section 610 of these rules, if the waiver services listed in Section 143 of these rules were not made available; and (3-20-04)
 - ii. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (3-20-04)
 - iii. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/MR care and other medical costs. (3-20-04)
 - iv. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-20-04)
- c.** A participant who is determined by the Department to be eligible for services under the Home and Community Based Services Waivers for ISSH and DD may elect to not utilize waiver services but may choose

admission to an ICF/MR. (3-20-04)

d. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (3-20-04)

e. The decisions of the Department or its designee regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-20-04)

07. Case Redetermination. (7-1-95)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, 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. (3-20-04)

b. The redetermination process will assess the following factors: (7-1-95)

i. The participant's continued need and eligibility for waiver services; and (3-20-04)

ii. Discharge from the waiver services program. (7-1-97)

08. 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 reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-20-04)

09. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (3-20-04)

a. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (3-20-04)

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 participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-20-04)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-20-04)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds

paid for undocumented services. (3-20-04)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 143.03 of these rules and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-20-04)

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". (3-20-04)

10. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-20-04)

11. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. (3-20-04)

12. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community based waiver for developmentally disabled participants 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 for the DD waiver and after June 30 for the ISSH waiver of each new waiver year. (3-20-04)

144. FEDERALLY QUALIFIED HEALTH CENTER (FQHC).

Federally qualified health centers are defined in federal law at 42 USC Section 1396d(1)(2), which incorporates the definition at 42 USC Section 1395x(aa)(1), and includes community health centers, migrant health centers or providers of care for the homeless, outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act, 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 Medical Assistance recipients. (5-3-03)

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 or clinical nurse specialist services; or (5-3-03)

e. Clinical psychologist services; or (4-1-90)

f. Clinical social worker services; or (4-1-90)

g. Licensed dentist and dental hygienist services; or (5-3-03)

h. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, or dentist or dental hygienist services which would otherwise be covered if furnished by or

incident to physician services; or (5-3-03)

i. 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)

j. Other payable Title XIX ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide, including pneumococcal or immunization vaccine and its administration. (5-3-03)

02. FQHC Encounter. An encounter is a face-to-face contact for the provision of medical, mental, or dental service between a center patient and a provider as specified in Subsections 144.01.a. through 144.01.g. of these rules. (5-3-03)

a. Each contact with a separate discipline of health professional (medical, mental, or dental), on the same day at the same location, is considered a separate encounter. All contacts with all practitioners within a disciplinary category (medical, mental, dental) on the same day is one (1) encounter. (5-3-03)

b. Reimbursement for services is limited to three (3) encounters per patient per day. (5-3-03)

c. As an exception to Subsection 144.02.a. of these rules, a second encounter with the same professional on the same day may be reimbursed; or (5-3-03)

d. As an exception to Subsection 144.02.b. of these rules, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (5-3-03)

03. Conditions of Participation. A qualified FQHC will be recognized as a Medicaid provider. (5-3-03)

145. RURAL HEALTH CLINICS (RHC).

Rural Health Clinic is a facility located in a rural area designated as a shortage area, and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases. (5-3-03)

01. Care and Services Provided. RHC services are defined as follows: (5-3-03)

a. Physician services; or (5-3-03)

b. Services and supplies incident to a physician service, which cannot be self administered; or (5-3-03)

c. Physician assistant services; or (5-3-03)

d. Nurse practitioner or clinical nurse specialist services; or (5-3-03)

e. Clinical psychologist services; or (5-3-03)

f. Clinical social worker services; or (5-3-03)

g. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered by a physician service; or (5-3-03)

h. A RHC located in an area with a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual. (5-3-03)

02. RHC Encounter. An encounter is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a provider as specified in Subsections 145.01.a. through 145.01.f. of these rules. (5-3-03)

- a.** Each contact with a separate discipline of health professional (medical or mental) on the same day at the same location is considered a separate encounter. (5-3-03)
- b.** Reimbursement for services is limited to two (2) encounters per patient per day. (5-3-03)
- c.** As an exception to Subsection 145.02.a. of these rules, a second encounter with the same professional on the same day may be reimbursed; or (5-3-03)
- d.** As an exception to Subsection 145.02.b. of these rules, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (5-3-03)
- e.** A core service ordered by a health professional who did not perform the service but was performed by support staff is considered a single encounter. (5-3-03)
- f.** Multiple contacts with clinic staff of the same discipline (medical, mental) on the same day related to the same illness or injury are considered a single encounter. (5-3-03)

03. Conditions of Participation. A qualified RHC will be recognized a Medicaid provider. (5-3-03)

146. PERSONAL CARE SERVICES (PCS).

Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. (3-20-04)

01. Personal Assistance Agency (PAA). A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services as defined in Section 669 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-20-04)

- a.** Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-20-04)
- b.** Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-20-04)
- c.** Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-20-04)
- d.** Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-20-04)
- e.** Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-20-04)
- f.** Assuring that all personal assistants meet the qualifications in Subsection 146.09 of these rules; (3-20-04)
- g.** Billing Medicaid for services approved and authorized by the RMS; (3-20-04)
- h.** Making referrals for PCS-eligible participants for service coordination as described in IDAPA

16.03.17, “Service Coordination,” when a need for these services is identified; and (4-6-05)

i. Assuring that it provides quality services in compliance with applicable rules. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (3-20-04)

02. Participant Eligibility Determination. The participant’s eligibility for PCS must be redetermined at least annually under Subsection 146.10 of these rules. (3-20-04)

a. Financial Eligibility. The participant must be financially eligible for Medical Assistance (MA) under IDAPA 16.03.01, “Eligibility for Health Care Assistance for Families and Children” or 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind and Disabled”. (3-20-04)

b. Medical Eligibility. All PCS must be provided under the order of a licensed physician or authorized provider. The physician or authorized provider must: (3-20-04)

i. Certify in writing that the services are medically necessary; (3-20-04)

ii. Recommend institutional placement of the participant if he identifies that PCS, in combination with other community resources or services offered through the Home and Community Based Waivers, are no longer sufficient to ensure the health or safety of the participant. (3-20-04)

c. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-20-04)

i. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS; (3-20-04)

ii. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed. A UAI is not to be completed for a child participant; (3-20-04)

iii. The RMS reviews the documentation for medical necessity; (3-20-04)

iv. The participant has a plan of care; and (3-20-04)

v. Services are ordered by a physician or authorized provider. (3-20-04)

d. State Plan Option. A participant who receives MA is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-20-04)

03. Service Limitations. (3-20-04)

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (3-20-04)

b. Children who meet the necessity criteria for EPSDT services under Section 536 of these rules may receive up to twenty-four (24) hours of PCS per day per child through the month of their twenty-first birthday. (3-20-04)

04. Medical Care and Services Provided. PCS services include medically-oriented tasks related to a participant’s physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant’s home or personal residence. The provider must deliver at least one (1) of the following services: (3-20-04)

- a.** Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (3-20-04)
- b.** Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; (3-20-04)
- c.** Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications; (3-20-04)
- d.** Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-20-04)
- e.** The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant; (3-20-04)
- f.** Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (3-20-04)

 - i.** The task is not complex and can be safely performed in the given participant care situation; (3-20-04)
 - ii.** A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; (3-20-04)
 - iii.** Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; (3-20-04)
 - iv.** Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (3-20-04)
 - v.** 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 participant's record; and (3-20-04)
 - vi.** Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. (3-20-04)
- g.** The provider is excluded from delivering the following services: (3-20-04)

 - i.** Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-20-04)
 - ii.** Insertion or sterile irrigation of catheters; (3-20-04)
 - iii.** Injecting fluids into the veins, muscles or skin; and (3-20-04)
 - iv.** Administering medication. (3-20-04)
- 05. Non-Medical Care and Services Provided.** PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 146.04.a. through 146.04.f. of this rule, the provider may also perform the following services: (3-20-04)

 - a.** Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room

cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. (3-20-04)

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (3-20-04)

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (3-20-04)

06. Place of Service Delivery. PCS may be provided only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home (CFH) or a Residential Care or Assisted Living Facility. The following living situations are specifically excluded as a personal residence: (3-20-04)

a. Certified nursing facilities (NFs) or hospitals. (3-20-04)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (3-20-04)

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, "Rules Governing Family and Children's Services". (3-20-04)

07. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho". The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes". The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-20-04)

a. The plan of care for participants who live in their own homes is based on: (3-20-04)

i. The physician's or authorized provider's information, including their orders for service; (3-20-04)

ii. The results of the UAI for adults, the Personal Assistance Agency's assessment for children and, if applicable, the QMRP's assessment and observations of the participant; and (3-20-04)

iii. Information obtained from the participant. (3-20-04)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-20-04)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-20-04)

08. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Mental Retardation Provider (QMRP). The RMS must identify the need for supervision. (3-20-04)

a. Oversight must include all of the following: (3-20-04)

i. Assistance in the development of the written plan of care; (3-20-04)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-20-04)

iii. Reevaluation of the plan of care as necessary; and (3-20-04)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-20-04)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QMRP as defined in 42 CFR 483.430. Oversight must include: (3-20-04)

i. Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-20-04)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-20-04)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-20-04)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-20-04)

09. Provider Qualifications for Personal Assistants. (3-20-04)

a. All personal assistants must have at least one (1) of the following qualifications: (3-20-04)

i. Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed professional nurse; (3-20-04)

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (3-20-04)

iii. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The RMS may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. (3-20-04)

b. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have completed one (1) of the Department-approved developmental disabilities training courses, or have experience providing direct services to people with developmental disabilities. RMS determines whether developmental disability training is required. Providers who are qualified as QMRPs are exempted from the Department-approved developmental disabilities training course. (3-20-04)

c. In order to serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: (3-20-04)

i. The RMS verifies that there are no other qualified providers available; (3-20-04)

ii. The provider is 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 provider status; and (3-20-04)

iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (3-20-04)

d. If PCS is paid for by Medicaid, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. (3-20-04)

e. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18), as defined in Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the provider's provider agreement. (3-20-04)

f. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a Certified Family Home under IDAPA 16.03.19, "Rules Governing Certified Family Homes". (3-20-04)

10. Annual Eligibility Redetermination. (3-20-04)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children" or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled". RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QMRP, or the physician or authorized provider. (3-20-04)

b. The medical redetermination must assess the following factors: (3-20-04)

i. The participant's continued need for PCS; (3-20-04)

ii. Discharge from PCS; and (3-20-04)

iii. Referral of the participant from PCS to a nursing facility. (3-20-04)

11. Criminal History Check. All PCS providers, including service coordinators, RN supervisors, QMRP supervisors and personal assistants, must participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check must be conducted in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (3-20-04)

12. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that he has a medical problem, he is required to submit a statement from a physician or authorized provider that his medical condition does not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. (3-20-04)

13. PCS Record Requirement -- Participant in His Own Home. The PCS record must be maintained on all participants who receive PCS in their own homes. (3-20-04)

a. Written Requirements. The PCS provider must maintain written documentation of every visit made to the participant's home and must record the following minimum information: (3-20-04)

i. Date and time of visit; (3-20-04)

ii. Length of visit; (3-20-04)

iii. Services provided during the visit; and (3-20-04)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-20-04)

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-20-04)

c. Plan of Care. The plan of care must contain all the elements required under Subsection 146.07 of these rules. (3-20-04)

d. A copy of the information required in Subsections 146.13.a. through 146.13.d. of this rule must be

maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-20-04)

e. Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsections 146.13.a. through 146.13.d. of this rule. (3-20-04)

14. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho". (3-20-04)

15. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes". (3-20-04)

16. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-20-04)

17. Provider Coverage Limitations. (3-20-04)

a. The provider must not bill for more time than was actually spent in service delivery. (3-20-04)

b. No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day. (3-20-04)

147. SERVICE COORDINATION FOR PERSONAL CARE SERVICE RECIPIENTS.

The Department will purchase service coordination services, as described in IDAPA 16.03.17, "Service Coordination," for Medicaid-eligible recipients who have been approved for personal care services (PCS). Services will be provided by an organized service coordination 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 services (RMS) staff. (4-6-05)

148. PROVIDER REIMBURSEMENT FOR PERSONAL ASSISTANCE SERVICES.

01. Reimbursement Rate. Personal assistance 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. (3-30-01)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMU under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as follows: (3-30-01)

a. Annually Medicaid 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, certified and non-certified nurse's aides) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year. (3-30-01)

b. Medicaid will then establish payment levels for personal assistance agencies for personal assistance services as follows: (3-30-01)

i. Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS

waiver:

Personal Assistance Agencies	WAHR x 1.55	=	\$ amount/hour
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(3-30-01)

- ii. Extended visit, one (1) child (eight and one-quarter (8.25) hours up to twenty-four (24) hours):

Personal Assistance 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/hour
Licensed Child Foster Homes	(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/hour

(4-11-06)

- iii. Extended visit, two (2) children (eight and one-quarter (8.25) hours up to twenty-four (24) hours):

Personal Assistance 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/hour
Licensed Child Foster Homes	(WAHR x hours actual care up to 4 hours x 1.22) plus (\$.65 x 1.22 x hours on site on-call)	=	\$ amount/hour

(4-11-06)

- iv. Adult participants living in Residential/Assisted Living Facilities (RALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (5-3-03)

(1) Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (4-11-06)

(2) Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (4-11-06)

(3) Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (4-11-06)

(4) Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, mental retardation, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, mental retardation, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 148.02.b.iv.(3) of these rules. (4-11-06)

c. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-30-01)

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 or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMU. (3-30-01)

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. PARTICIPATION IN THE COST OF WAIVER SERVICES.

01. Waiver Services and Income Limit. A participant is not required to participate in the cost of Home and Community Based (HCBS) waiver services unless: (5-3-03)

a. The participant's eligibility for Medical Assistance (MA) is based on approval for and receipt of a waiver service; and (5-3-03)

b. He would not be income eligible because of excess income if not for the HCBS income limit contained in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. (5-3-03)

02. Excluded Income. Income excluded under the provisions of IDAPA 16.03.05.723 and 16.03.05.725 is excluded in determining participation. (5-3-03)

03. Base Participation. Base participation is income available for participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 149.06. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the RMU or ACCESS unit. (5-3-03)

04. Community Spouse. Except for the elderly or physically disabled participant's personal needs allowance, base participation for a recipient with a community spouse is calculated under IDAPA 16.03.05.725. These allowances are specified in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)". A community spouse is the spouse of an HCBS recipient who is not an HCBS recipient and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently. (5-3-03)

05. Home and Community Based Services (HCBS) Spouse. Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled," Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS. (5-3-03)

06. Personal Needs Allowance. The participant's personal needs allowance depends on his marital status and legal obligation to pay rent or mortgage. The participant's personal needs allowance is deducted from his income after income exclusions and before other allowable deductions. To determine the amount of the personal needs allowance, use Table 149.06: (5-3-03)

TABLE 149.06 - PERSONAL NEEDS ALLOWANCE			
Amount of Personal Needs Allowance (PNA) for Participation			
Not Responsible for Rent or Mortgage		Responsible for Rent or Mortgage	
Marital Status	PNA	Marital Status	PNA
No Spouse	One-hundred percent (100%) of the federal SSI benefit for a person with no spouse	No Spouse	One-hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse
Married with Community Spouse	One-hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse	Married with Community Spouse	One-hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse

TABLE 149.06 - PERSONAL NEEDS ALLOWANCE			
Amount of Personal Needs Allowance (PNA) for Participation			
Not Responsible for Rent or Mortgage		Responsible for Rent or Mortgage	
Marital Status	PNA	Marital Status	PNA
Married with HCBS Spouse	One-hundred percent (100%) of the Federal SSI benefit for a person with no spouse. Each spouse receives this amount as his PNA.	Married with HCBS Spouse	One-hundred and fifty percent (150%) of the Federal SSI benefit for a single person. Each spouse receives this amount as his PNA.

(5-3-03)

07. Developmentally Disabled or TBI Participants. These allowances are specified in IDAPA 16.03.05, “Rules Governing Eligibility for Aid To The Aged, Blind, and Disabled (AABD)”. The HCBS personal needs allowance for participants receiving Waiver Services for Adult Developmentally Disabled Recipients or participants receiving services under the Adult Traumatic Brain Injury (TBI) waiver, is three (3) times the federal SSI benefit amount to an individual in his own home. (4-5-00)

08. 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 a participant’s incurred expenses for such limited services meet the criteria for deduction. The participant must report such expenses and provide verification in order for an expense to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance and will not be considered a medical expense. 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 participant. (5-3-03)

09. Remainder After Calculation. Any remainder after the calculation in Subsection 149.06 is the maximum participation to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be collected from the participant by the provider. The provider and the participant will be notified by the Department of the amount to be collected. (5-3-03)

10. Recalculation of Participation. The participant’s participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (5-3-03)

11. Adjustment of Participation Overpayment or Underpayment Amounts. The participant’s participation amount is reduced or increased the month following the participant overpaid or underpaid the provider. (5-3-03)

150. EMERGENCY TRANSPORTATION.

01. 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: (3-15-02)

a. If a Medicaid recipient is also a Medicare recipient, a provider must first bill Medicare for services rendered. (7-1-98)

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure a Medicare Summary Notice (MSN) from Medicare, attach it to the appropriate claim form and submit it to the Department.

(5-3-03)

c. For Medicare recipients, the Department will reimburse providers for services up to the Medicaid allowable amount minus the Medicare payment.

(5-3-03)

d. Before payment is made by the Department, a Medicaid recipient must utilize any available insurance benefits to pay for ambulance services.

(7-1-98)

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.

(7-1-98)

f. 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.

(7-1-98)

g. 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.

(7-1-98)

h. Ambulance services providers cannot charge Medicaid recipients more than is charged to the general public for the same service.

(7-1-98)

02. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when:

(7-1-98)

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 will be authorized by the Department or its designee on a retrospective basis.

(4-6-05)

e. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the recipient.

(7-1-98)

03. Ambulance Reimbursement. (7-1-98)

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the recipient during transport. In addition to the base rate, the Department will reimburse mileage. (4-6-05)

b. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department or its designee. (7-1-98)

c. If a physician is in attendance during transport, he is responsible for the billing of his services. (11-10-81)

d. 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. (7-1-98)

e. 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 maintain. At least this level of personnel is required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the following: (4-6-05)

i. The level of personnel required to be in the patient compartment of the ambulance; (4-6-05)

ii. The level of ambulance license the unit has been issued; and (4-6-05)

iii. The level of life support authorized by the Department. (4-6-05)

f. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to 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 up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a recipient's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. (4-6-05)

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 ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department or its designee. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI 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 ALSI or ALSII 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 ALSI, ALSII, 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. (4-6-05)

h. If multiple licensed EMS providers transport a recipient for different legs of a trip, each provider must bill his base rate and mileage, as authorized by the Department or its designee. (4-6-05)

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. This service requires authorization from the Department or its designee, usually on a retrospective basis. (4-6-05)

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. (7-1-98)

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. (7-1-98)

l. If a licensed transporting EMS provider responds to a recipient's location and upon examination and evaluation of the recipient, finds that his 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 to an EMS provider who is licensed as a non-transporting provider. (4-6-05)

m. All ambulance providers will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (4-6-05)

151. NON-EMERGENCY TRANSPORTATION.

01. General Coverage for Non-Emergency Transportation. Non-emergency transportation is all transportation that is not of an emergency nature, including non-medical transportation under waiver programs. An emergency is a condition described in Subsection 150.01.e. of these rules. Medicaid will reimburse non-emergency transportation by commercial or non-commercial transportation providers under the following circumstances and limitations: (1-1-06)T

a. The travel is essential to get to or from a medically necessary service or a waiver service covered by Medicaid; and (3-15-02)

b. The person for whom services are billed is actually transported for all the distance billed; and (3-15-02)

c. The mode of transportation is the lowest in cost to the Medicaid program that is appropriate to the medical needs of the participant; and (1-1-06)T

d. The transportation is to the nearest medical or waiver service provider appropriate to perform the needed services, and transportation is by the most direct route practicable. Reimbursement will be limited to the distance of the most direct route practicable; and (3-15-02)

e. Other modes of transportation, including personal vehicle, assistance by family, friends and charitable organizations, are unavailable or impractical under the circumstances; and (3-15-02)

f. The travel is authorized by the Department prior to the transportation; and (3-15-02)

g. Authorization for the travel is requested from the Department at least twenty-four (24) hours in advance of the travel to the medical appointment or waiver service excluding Saturdays, Sundays, and state holidays; and (3-15-02)

- h.** The transporter has completed and signed a current Medicaid provider agreement; and (3-15-02)
- i.** Travel is not covered by the service to which the participant is being transported; and (1-1-06)T
- j.** Transportation is paid on a reimbursement basis only; payment will not be issued prior to delivery of the service. (3-15-02)

02. Exceptions. Despite the preceding rules, Medicaid will cover transportation services under the following circumstances: (3-15-02)

a. Transportation services may be retroactively approved when a participant is found retroactively eligible, the transportation service falls within the period of retroactive eligibility, and the transporter was a Medicaid transportation provider at the time of the transport for which reimbursement is sought. (1-1-06)T

b. If the trip distance is less than twenty-one (21) miles, prior approval for non-commercial non waiver transport is not necessary. For Subsection 151.02 of this rule, a trip is the distance a transporter carries a participant in the course of a day. Therefore, the total mileage of a round-trip transport that takes place within one (1) day will be considered in determining whether this exception applies. Even though prior approval is not required, the transporter shall maintain all records as described in Subsection 152.02.c. of these rules. This exception is not available to commercial providers. (1-1-06)T

c. Reimbursement for non-commercial transportation will be limited as required by Section 56-227E, Idaho Code, and as expressed in Subsection 152.02.b. of this rule. (1-1-06)T

d. Non-Emergency transportation for Medicaid participants who are also eligible for Medicare (“dual eligibles”) when they require transportation to pick up their medications covered under Medicare, Part D. (1-1-06)T

03. Services Incidental to Travel. Medicaid will reimburse for the reasonable cost actually incurred of meals, lodging, a personal assistant and other necessary services incidental to travel, only under the following conditions: (3-15-02)

a. Approval of the service is requested from the Department at least twenty-four (24) hours in advance of the travel. Excluding Saturdays, Sundays, and state holidays. (3-15-02)

b. The reasonable cost of meals actually incurred in transit will be approved when necessary, when there is no other practical means of obtaining food, and only when an overnight stay is required to receive the service. Reimbursement shall not exceed seven dollars (\$7) per meal or a maximum of twenty-one dollars (\$21) per day per person. (5-3-03)

c. The reasonable cost actually incurred for lodging will be approved when the round trip and the needed medical service, in practicality, can not be completed in the same day. The travel must entail a one (1) way distance of at least two hundred (200) miles, or a normal one (1) way travel time of at least four (4) hours. The incidental travel expenses of a family member or other companion will be covered when medical necessity or the vulnerability of the individual requires accompaniment for safety, and no less-costly alternative is available. Lodging reimbursement will not be paid when the stay is in the home of a relative or acquaintance. (3-15-02)

152. REQUIREMENTS OF NON-EMERGENCY TRANSPORTATION PROVIDERS.

01. Commercial Transportation Provider. A commercial transportation provider is an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By “holding itself out” to the general public, the provider vigorously and diligently solicits riders from the general populace, as opposed to primarily serving riders from one (1) or more congregate living facilities. By “actually providing” services to the general public, the provider’s riders include substantial numbers of persons whose travel is funded by a source other than Medicaid. (3-15-02)

a. Payment conditioned on prior approval. Medicaid will reimburse commercial transportation services only when approved at least twenty-four (24) hours in advance of the services, as provided in Subsection 151.01.f., or under the exception stated in Subsection 151.02.a. (3-15-02)

b. Minimum qualifications. Each commercial transportation provider must, at minimum, meet the following standards: (3-15-02)

i. Maintain all certifications and licenses for drivers and vehicles required by all public transportation laws, regulations, ordinances that apply to the transportation provider. (3-15-02)

ii. Adhere to all laws, rules and regulations applicable to transportation providers of that type, including those requiring liability insurance. Liability insurance will be carried in an amount to cover at least five hundred thousand dollars (\$500,000) personal injury and five hundred thousand dollars (\$500,000) property damage per occurrence. (3-15-02)

iii. Enter into a Medicaid provider agreement and enrollment application. (3-15-02)

c. Records. Each commercial provider shall maintain the following records for a minimum of five (5) years. (3-15-02)

i. Prior authorization documents. (3-15-02)

ii. Name of client and Medicaid ID number. (3-15-02)

iii. Date, time and geographical point of pick-up for each client trip. (3-15-02)

iv. Date, time and geographical point of drop-off for each client trip. (3-15-02)

v. Identification of the vehicle(s) and driver(s) transporting each client on each trip, and total miles for the trip. (3-15-02)

02. Non-Commercial Transportation Provider. Any transportation provider that does not meet the definition of a commercial transportation provider is a non-commercial transportation provider. Non-commercial transportation services may be performed by an agency or by an individual provider. Agency transporters are entities that provide transportation as well as at least one other service to one or more Medicaid clients. Individual transporters are non-commercial providers who transport a family member, acquaintance or other person in a personal vehicle. If the Medicaid clients being transported are also clients of the transportation provider for services such as residential care, mental health, developmental therapy or other services, the provider will be considered a non-commercial provider with respect to those clients, even if the provider otherwise qualifies as a commercial transporter. A provider will be considered non-commercial with respect to any Medicaid clients transported if those clients are being transported to or from another service in which the provider has any ownership or control or if the arrangement to provide transportation is not an arm's length transaction. (3-15-02)

a. Hardship Exception. The Department may grant an exception on the basis of hardship. The provider must submit information to show at minimum that its reasonable costs of vehicle operation exceed the applicable reimbursement rate. In evaluating requests for exception, the Department will consider factors such as alternative forms of services and transportation available in the area, the cost of alternatives, the appropriateness of the vehicles utilized and the benefit to clients. Special consideration may be given to any provider servicing the area through a grant from the Federal Transit Administration. The Department may limit the exception including the amount of additional reimbursement, the type of services to which transportation is being provided, and the time duration of the exception. (3-15-02)

b. Minimum qualifications. Each non-commercial transportation provider must, at minimum, meet the following standards: (3-15-02)

i. Continuously maintain liability insurance that covers passengers. For agency providers, coverage must be at least one-hundred thousand (\$100,000) per individual and three-hundred thousand (\$300,000) each

incident. Individual providers must carry at least the minimum liability insurance required by Idaho law. If an agency permits employees to transport clients in employees' personal vehicles, the agency must ensure that adequate insurance coverage is carried to cover those circumstances. (3-15-02)

ii. Obtain and maintain all licenses and certifications required by government to conduct business and to operate the types of vehicles used to transport clients. Agencies shall maintain documentation of appropriate licensure for all employees who operate vehicles. (3-15-02)

iii. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. (3-15-02)

iv. Enter into a Medicaid enrollment application and provider agreement. (3-15-02)

c. Records. Each non-commercial transportation provider shall, at the time of transport, collect the following information, and shall maintain it for a minimum of five (5) years: (3-15-02)

i. Client name and Medicaid ID number for each trip. (3-15-02)

ii. Date, time, geographical point of pick-up and odometer reading at pick-up for each client trip. (3-15-02)

iii. Date, time, geographical point of drop-off and odometer reading at drop-off for each client trip. (3-15-02)

iv. Mileage each client was transported for each trip billed. (3-15-02)

v. Identification of the vehicle and driver transporting each client on each trip. (3-15-02)

vi. Notice of prior authorization, when required. (3-15-02)

03. Claims for Travel-Related Services. All claims for travel-related services must be supported by receipts, or other verification of the date, place, the amount of and the nature of services that were performed. Medicaid will not pay for claimed services that are not verifiable by contemporaneous documentation. (3-15-02)

04. Submission of Transportation Claims. All transportation claims shall be on a HCFA 1500 Claim form and shall include a trip-related authorization number where prior authorization is required. Payment shall not be made in advance of the service being rendered. (3-15-02)

153. REIMBURSEMENT RATES.

01. Commercial Transportation. A statewide uniform payment rate shall be established through a study conducted no less frequently than each third year, that evaluates the actual charges of, and costs reasonably incurred by the typical commercial transportation provider, together with the reasonable administrative costs incurred by the typical provider in keeping records for Medicaid-related transportation and billing the Department. (5-3-03)

02. Non-Commercial Providers -- Agency and Individual. (5-3-03)

a. Agency Provider Reimbursement. A statewide uniform payment rate shall be established through a study conducted no less frequently than each third year, that evaluates the actual costs reasonably incurred by the typical agency transportation provider, together with the reasonable administrative costs incurred by the typical agency transportation provider in keeping records for Medicaid-related transportation and billing the Department. (5-3-03)

b. Individual Provider Reimbursement. A uniform payment rate shall be established through a study conducted no less frequently than each third year, that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. (5-3-03)

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 Subsection 160.01.a. and Subsection 180.08, and social and recreational activities. DHW authorized purchases of specialized wheelchair and seating systems, and any authorized repairs related to the seating system, which are paid to a medical vendor directly by DHW will not be included in the content of care of ICFs/MR. The specialized wheelchairs and seating systems must be designed to fit the needs of a specific ICF/MR resident and cannot be altered to fit another client cost effectively. (7-1-99)

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. This adjustment will only be available up through September 30, 1996. (7-1-99)

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 16.03.10, "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, Section 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 16.03.05, Subsection 522.02.c., "Rules Governing Eligibility for Aid for Families with Dependent Children (AFDC)"). (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 p.m. and is not discharged to a related ICF/MR provider. If a Medicaid patient dies in a nursing home, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care shall be deemed to exist. (7-1-99)

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 per calendar year so long as the days are part of a treatment plan ordered by the attending physician. (7-1-99)

ii. Therapeutic home visits for ICF/MR residents of up to thirty-six (36) days per calendar year 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. (7-1-99)

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 16.03.10, "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 eight hundred dollars (\$1800) for a single individual or two thousand eight hundred dollars (\$2,800) for a married couple; and (7-1-99)

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. (7-1-98)

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. (7-1-98)

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. (7-1-98)

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 16.05.03, 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. (7-1-98)

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. (8-23-90)

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)

a. The recipient is determined to be entitled to such services in accordance with Subsection 080.01; and (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 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (7-1-94)

e. The Department will pay the lessor 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. (8-1-94)

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 16.03.10, "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 16.03.05, "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. -- 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. -- 199. (RESERVED).

200. FRAUD, ABUSE, AND MISCONDUCT.

This section is intended to protect the integrity of the state plan by identifying instances of fraud, abuse, 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 Section 56-227B, Idaho Code. (4-5-00)

201. DEFINITIONS - FRAUD, ABUSE AND MISCONDUCT.

For purposes of Sections 200 through 233, unless the context clearly requires otherwise, the following words and terms will have the following meanings: (3-20-04)

01. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. It also includes recipient practices that result in unnecessary cost to the Medicaid program, or recipient utilization practices which may endanger their personal health or safety. (4-5-00)

02. Access to Documentation and Records. To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 202 of these rules. (3-20-04)

03. Claim. Any request or demand for payment of items or services under the state's medical

assistance program, whether under a contract or otherwise. (4-5-00)

04. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (3-30-01)

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-01)

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-01)

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or (3-30-01)

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-01)

05. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (4-5-00)

06. 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. (4-5-00)

07. Knowingly, Known, or with Knowledge. A person, with respect to information or an action, who: has actual knowledge of the information or an action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (4-5-00)

08. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (4-5-00)

09. Medical Assistance. Shall mean payments for part or all of the cost of such care and services allowable within the scope of Title XIX and XXI of the federal Social Security Act as amended as may be designated by Department rules. (4-5-00)

10. Ownership or Control Interest. A person or entity that: has an ownership interest totaling twenty-five percent (25%) or more in an entity; is an officer or director of an entity that is organized as a corporation; is a partner in an entity that is organized as a partnership; or is a managing member in an entity that is organized as a limited liability company. (4-5-00)

11. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (4-5-00)

12. Program. The Medicaid Program or any part thereof, including Idaho's state plan. (4-5-00)

13. Recoup and Recoupment. The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. (3-20-04)

14. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 224 of these rules. (4-5-00)

15. State Plan. The Medicaid Program as it exists in Idaho. (4-5-00)

202. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.

01. Documentation of Services. Providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media. (3-20-04)

02. Immediate Access to Records. Providers must grant to the Department and its agents, the U.S. Department of Health and Human Services and its agents, immediate access to records for review and copying during normal business hours. These records are defined in Subsection 202.01 of these rules (3-20-04)

03. Copying Records. The Department and its authorized agents may copy any record as defined in Subsection 202.01 of these rules. They may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records. (3-20-04)

04. Removal of Records from Provider's Premises. The Department and its authorized agents may remove from the provider's premises copies of any records as defined in Subsection 202.01 of these rules. (3-20-04)

203. INVESTIGATION AND AUDITS.

Investigation and audits of provider fraud, abuse or misconduct conducted by the Department's Bureau of Audits and Investigations or its successor are governed under Sections 200 through 233 of these rules. (3-20-04)

01. Investigation Methods. Under Section 56-227(e), Idaho Code, the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to involvement in the program. Methods may include, but are not limited to, review of computerized reports, referrals to or from other agencies, health care providers or persons, or conducting audits and interviews, probability sampling and extrapolation, and issuing subpoenas to compel testimony or the production of records. Reviews may occur on either pre-payment or post-payment basis. (3-20-04)

02. Probability Sampling. Probability sampling shall be done in conformance with generally accepted statistical standards and procedures. "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events). (3-30-01)

03. Extrapolation. Whenever the results of a probability sample are used to extrapolate the amount to be recovered, the demand for recovery shall be accompanied by a clear description of the universe from which the sample was drawn, the sample size and method used to select the sample, the formulas and calculation procedures used to determine the amount to be recovered, and the confidence level used to calculate the precision of the extrapolated overpayment. "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated precision (margin of error). (3-30-01)

204. SURVEILLANCE AND UTILIZATION REVIEW (S/UR) COMMITTEE.

Instances of suspected fraud, abuse, or other misconduct may be referred to a review committee organized by the Department. The committee shall consist of health professionals and other staff appointed by the Director or his designee. The committee may also consult with other professionals as determined necessary by the committee. The function of the committee will be to review and make recommendations concerning corrective action. (4-5-00)

205. DEPARTMENT ACTIONS.

When an instance of fraud, abuse, or other misconduct is identified, the Department will take action to correct the problem as provided in this section. Such corrective action may include, but is not limited to, denial of payment, recoupment, payment suspension, provider agreement suspension, termination of provider agreement, imposition of civil monetary penalties, exclusion, recipient lock-in, referral for prosecution, or referral to state licensing boards. (3-20-04)

206. DENIAL OF PAYMENT.

The following are reasons the Department may deny payment. (3-20-04)

01. Billed Services Not Provided or Not Medically Necessary. The Department may deny payment for any and all claims it determines are for items or services: (3-20-04)

a. Not provided or not found by the Department to be medically necessary. (3-20-04)

b. Not documented to be provided or medically necessary. (3-20-04)

c. Not provided in accordance with professionally recognized standards of health care. (3-20-04)

d. Provided as a result of a prohibited physician referral under 42 CFR Part 411, Subpart J. (3-20-04)

02. Contrary to Rules or Provider Agreement. The Department may deny payment when services billed are contrary to Department rules or the provider agreement. (3-20-04)

03. Failure to Provide Immediate Access to Records. The Department may deny payment when the provider does not allow immediate access to records as defined in Section 202 of these rules. (3-20-04)

207. RECOUPMENT.

The Department may recoup the amount paid for items or services listed in Section 206 of these rules. If recoupment is impracticable, the Department may pursue any available legal remedies it may have. Interest shall accrue on overpayments at the statutory rate set forth in Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for items or services until the date of recovery. (3-30-01)

208. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.

The Department may suspend payments in whole or part in a suspected case of fraud or abuse pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. (3-20-04)

01. Basis for Suspension of Payments. When the Department through reliable evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended. (3-20-04)

02. Notice of Suspension of Payments. The Department may withhold payments without first notifying the provider of its intention to do so. The Department will send written notice according to 42 CFR 455-23(b) within five (5) days of taking such action. (3-20-04)

03. Duration of Suspension of Payments. The withholding of payment actions under Section 208 of these rules will be temporary and will not continue after: (3-20-04)

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (3-20-04)

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (3-20-04)

209. PROVIDER AGREEMENT SUSPENSION.

In the event the Department identifies a suspected case of fraud or abuse, it may summarily suspend the provider agreement when such action is necessary to prevent or avoid immediate danger to the public health or safety. This provider agreement suspension temporarily bars the provider from participation in the Medicaid Program, pending investigation and Department action. The Department will notify the provider of the suspension. The suspension is effective immediately upon written, electronic, or oral notification. (3-20-04)

210. APPEAL OF IMMEDIATE ACTION.

When payments have been suspended or withheld or the provider's agreement is suspended pending investigation, the Department shall provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal.

(4-5-00)

211. TERMINATION OF PROVIDER STATUS.

Pursuant to Section 56-209h, Idaho Code, the Department may terminate the provider agreement of, or otherwise deny provider status for a period of five (5) years from the date the Department's action becomes final to, any individual or entity who: (4-5-00)

01. Submits an Incorrect Claim. Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item or amount is specifically identified. (4-5-00)

02. Fraudulent Claim. Submits a fraudulent claim. (4-5-00)

03. Knowingly Makes a False Statement. Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the Department. (4-5-00)

04. Medically Unnecessary. Submits a claim for an item or service known to be medically unnecessary. (4-5-00)

05. Immediate Access to Documentation. Fails to provide, upon written request by the Department, immediate access to documentation required to be maintained. (4-5-00)

06. Non-Compliance with Rules and Regulations. Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments. (4-5-00)

07. Violation of Material Term or Condition. Knowingly violates any material term or condition of its provider agreement. (4-5-00)

08. Failure to Repay. Has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement. (4-5-00)

09. Fraudulent or Abusive Conduct. Has been found, or was a managing employee in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care items or services. (4-5-00)

10. Failure to Meet Qualifications. Fails to meet the qualifications specifically required by rule or by any applicable licensing board. (4-5-00)

212. CIVIL MONETARY PENALTIES.

Under Section 56-209h, Idaho Code, the Department may assess civil monetary penalties against a provider, any officer, director, owner, and managing employee for conduct identified in Subsections 211.01 through 211.09 of these rules. The amount of penalties may be up to one thousand dollars (\$1,000) for each item or service improperly claimed, except that in the case of multiple penalties the Department may reduce the penalties to not less than twenty-five percent (25%) of the amount of each item or service improperly claimed if an amount can be readily determined. Each line item of a claim, or cost on a cost report is considered a separate claim. These penalties are intended to be remedial, at a minimum recovering costs of investigation and administrative review, and placing the costs associated with non-compliance on the offending provider. (3-20-04)

213. MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.

The Department will exclude from the Medicaid Program any provider, entity or person that: (3-20-04)

01. Conviction of a Criminal Offense. Has been convicted of a criminal offense related to the delivery of an item or service under a federal 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. (4-5-00)

02. Conviction of a Criminal Offense Related to Patient Neglect or Abuse. 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. (4-5-00)

03. Other Exclusions. Is identified by the Centers for Medicare and Medicaid Services (CMS) as having been excluded by another state or the Office of Inspector General or any person CMS directs the Department to exclude. (3-20-04)

214. TERMS OF MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.

Mandatory exclusions from the Medicaid Program imposed under Subsections 213.01 and 213.02 of these rules, will be for not less than ten (10) years. The exclusion may exceed ten (10) years if aggravating factors are present. In the case of any mandatory exclusion of any person, if the individual has been convicted on two (2) or more previous occasions of one (1) or more offenses for which an exclusion may be effected under this section, the period of exclusion will be permanent. (3-20-04)

215. PERMISSIVE EXCLUSIONS FROM THE MEDICAID PROGRAM.

The Department may exclude any person or entity from the Medicaid Program for a period of not less than one (1) year: (3-20-04)

01. Endangerment of Health or Safety of a Patient. Where there has been a finding by a governmental agency against such person or entity of endangering the health or safety of a patient, or of patient abuse, neglect or exploitation. (3-20-04)

02. Failure to Disclose or Make Available Records. That has failed or refused to disclose, make available, or provide immediate access 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, which the Department deems relevant to determining the appropriateness of payment. (3-20-04)

03. Other Exclusions. For any reason for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity. (3-30-01)

216. AGGRAVATING FACTORS.

For purposes of lengthening the period of mandatory exclusions and permissive exclusions from the Medicaid Program, the following factors may be considered. This is not intended to be an exhaustive list of factors which may be considered: (3-20-04)

01. Financial Loss. The 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 program. (4-5-00)

02. Time Acts Were Committed. The acts were committed over a period of one (1) year or more. (4-5-00)

03. Adverse Impact. The acts had a significant adverse physical, mental or financial impact on one (1) or more program recipients or other individuals. (4-5-00)

04. Length of Sentence. The length of any sentence imposed by the court related to the same act. (4-5-00)

05. Prior Record. The excluded person has a prior criminal, civil or administrative sanction record. (4-5-00)

217. REFUSAL TO ENTER INTO AN AGREEMENT.

The Department may refuse to enter into a provider agreement if the provider: (3-20-04)

- 01. Convicted of a Felony.** Has been convicted of a felony under federal or state law; or (3-20-04)
- 02. Committed an Offense or Act Not in Best Interest of Medicaid Recipients.** Has committed an offense or act which the Department determines is inconsistent with the best interests of Medicaid recipients; or (3-20-04)
- 03. Failed to Repay.** Has failed to repay the Department monies which had been previously determined to have been owed to the Department; or (3-20-04)
- 04. Investigation Pending.** Has a pending investigation for program fraud or abuse; or (3-20-04)
- 05. Terminated Provider Agreement.** Was the managing employee, officer, or owner of an entity whose provider agreement was terminated under Section 211 of these rules. (3-20-04)

218. 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: (4-5-00)

- 01. Issuance of a Warning.** 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. (4-5-00)
- 02. Review.** Prepayment review of all or selected claims submitted by the provider with notice that claims failing to meet written guidelines will be denied. (4-5-00)
- 03. Referral.** Referral to state licensing boards for review of quality of care and professional and ethical conduct. (4-5-00)

219. 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 Section. (4-5-00)

220. PROVIDER NOTIFICATION.

When the Department determines actions defined in Sections 205 through 217 of these rules are appropriate, it will send written notice of the decision to the provider or person. The notice will state the basis for the action, the length of the action, the effect of the action on that person's ability to provide services under state and federal programs, and the person's appeal rights. (4-5-00)

221. NOTICE TO STATE LICENSING AUTHORITIES.

The Department will promptly notify all appropriate licensing authorities having responsibility for licensing or certification of a Department action, and the facts and circumstances of that action. The Department may request certain action be taken and that the Department be informed of actions taken. (4-5-00)

222. PUBLIC NOTICE.

The Department will give notice of the action taken and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate, including, but not limited to, related providers, the Quality Improvement Organization (QIO), institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. (3-20-04)

223. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The Department shall notify the Office of Inspector General within fifteen (15) days after a final action in which a person has been excluded or convicted of a criminal offense related to participation in the delivery of health care items or services under the program. (4-5-00)

224. APPEAL OF DEPARTMENT ACTION.

Any department action, may be appealed as a contested case under the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (3-20-04)

225. RECIPIENT UTILIZATION CONTROL PROGRAM.

This 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. Recipients demonstrating unreasonable patterns of utilization and/or exceeding reasonable levels of utilization shall be reviewed for restriction. The Department may require a recipient to designate a primary physician and/or a single pharmacy for exclusive provider services in an effort to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of Medical Assistance, and avoid excessive utilization of prescription medications. (4-5-00)

226. LOCK-IN DEFINED.

Lock-in is the process of restricting the access of a recipient to a specific provider or providers. (4-5-00)

227. DEPARTMENT EVALUATION FOR LOCK-IN.

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. (4-5-00)

228. CRITERIA FOR LOCK-IN.

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 Department 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. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the recipient's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a recipient to a single provider or providers: (4-5-00)

01. Unnecessary Use of Providers or Services. Unnecessary use of providers or Medicaid services, including excessive provider visits. (4-5-00)

02. Demonstrated Abusive Patterns. Recommendation from a medical professional or the recipient's primary care physician that the recipient has demonstrated abusive patterns and would benefit from the lock-in program. (4-5-00)

03. Use of Emergency Room Facilities. Frequent use of emergency room facilities for non-emergent conditions. (4-5-00)

04. Multiple Providers. Use of multiple providers. (4-5-00)

05. Controlled Substances. Use of multiple controlled substances. (4-5-00)

06. Prescribing Physicians or Pharmacies. Use of multiple prescribing physicians and/or pharmacies. (4-5-00)

07. Prescription Drugs and Therapeutic Classes. Overlapping prescription drugs with the same therapeutic class. (4-5-00)

08. Drug Abuse. Drug abuse and/or drug withdrawal diagnosis. (4-5-00)

09. Drug Behavior. Drug seeking behavior as identified by a medical professional. (4-5-00)

10. Other Abusive Utilization. Use of drugs or other Medicaid services determined to be abusive by

the Department's medical or pharmacy consultant. (4-5-00)

229. LOCK-IN RECIPIENT NOTIFICATION.

A recipient who has been designated by the Department for the Recipient Utilization Control Program will be notified in writing by the Department of the action and the recipient's right of appeal by means of a fair hearing. (4-5-00)

230. LOCK-IN PROCEDURES.

01. Recipient Responsibilities. The recipient will be given thirty-five (35) days to contact the Regional Program Manager or designee and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. (4-5-00)

02. Appeal Stays Restriction. The Department shall not implement the recipient restriction if a valid appeal is noted pursuant to Section 232 of these rules. (4-5-00)

03. Lock-In Duration. The Department shall restrict recipients to their designated providers for a time period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. (4-5-00)

04. Payment to Providers. Payment to provider(s) other than the designated lock-in physician or pharmacy is limited to documented emergencies or written referrals from the primary physician. (4-5-00)

05. Regional Programs Manager. The Regional Programs Manager, or designee will: (4-5-00)

a. Clearly describe the recipient's appeal rights in accordance with the provisions in Section 232 of these rules; (4-5-00)

b. Specify the effective date and length of the restriction; (4-5-00)

c. Have the recipient choose a designated provider or providers; and (4-5-00)

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the recipient's Medicaid services will be immediately restricted to the designated provider(s). (4-5-00)

231. PENALTIES FOR LOCK-IN NONCOMPLIANCE.

If a recipient fails to respond to the notification of medical restriction(s), fails to sign the lock-in agreement, or fails to select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. 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. (4-5-00)

232. APPEAL OF LOCK-IN.

Department determinations to lock-in a recipient may be appealed in accordance with the fair hearings provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," of the Department. (4-5-00)

233. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Monthly Surveys. The Department will conduct monthly surveys of services rendered to Medical Assistance recipients using REOMBS. (4-5-00)

02. Recipient Response. A Medical Assistance recipient is required to respond to the Department's explanation of medical benefits survey whenever he is aware of discrepancies. (4-5-00)

03. Recipient Unable to Respond. 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. (4-5-00)

04. 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. (4-5-00)

234. -- 299. (RESERVED).

300. 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)

301. -- 349. (RESERVED).

350. 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)

351. -- 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. -- 448. (RESERVED).

449. DEFINITIONS FOR PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).

01. Assessment Hours. Time allotted for completion of evaluation and diagnostic services. (4-6-05)

02. Credentialing. A process where the Medicaid PSR agency is approved by the Department or the Department's designee as having met the requirements of the provider agreement and professional standards defined in these rules. (5-1-06)T

03. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (4-6-05)

04. Goal. The desired outcome related to an identified issue. (4-6-05)

05. Initial Contact. The date a participant, parent, or legal guardian signs the request for assessment hours. (4-6-05)

06. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (4-6-05)

07. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. (4-6-05)

08. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (4-6-05)

09. Psychosocial Rehabilitative Services (PSR). Rehabilitative services provided both to children with serious emotional disturbance and to adults with severe and persistent mental illness to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills. (4-6-05)

10. Tasks. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (4-6-05)

450. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).

Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department or its designee in each region will cover psychosocial rehabilitative services (PSR) for maximum reduction of mental disability. For PSR provided by a school district under an individualized education plan (IEP), refer to Section 560 of these rules. (4-6-05)

01. PSR Eligibility Criteria for Children. A seriously emotionally disturbed child is an individual under the age of eighteen (18) who has a serious emotional disturbance (SED). The following definition of the SED target population is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code. (4-6-05)

a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and (4-6-05)

b. Requires sustained treatment interventions; and (3-15-02)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-15-02)

d. The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires a full eight (8) scale score of eighty (80) or higher with "moderate" impairment in at least one (1) of the following three (3) scales: (4-6-05)

i. Self-Harmful Behavior; (3-15-02)

ii. Moods/Emotions; or (3-15-02)

iii. Thinking. (3-15-02)

e. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (4-6-05)

02. PSR Eligibility Criteria for Adults. A severely and persistently mentally ill adult is any individual eighteen (18) years or older who has a severe and persistent mental illness. The following criteria are required to be a member of the target population based on the guidelines taken from the Federal Register under Section 1912(c) of the Public Health Services Act and as amended by Public Law 102-321 "adults with a serious mental illness". (4-6-05)

a. The individual must have a diagnosis under DSM-IV-TR or subsequent revisions to the DSM, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder recurrent severe, Delusional Disorder, or Borderline Personality Disorder. The only NOS diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a more conclusive diagnosis; and (4-6-05)

b. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following areas on either a continuous or an intermittent (at least once per year) basis: (3-15-02)

i. Vocational/educational; (4-6-05)

ii. Financial; (3-15-02)

- iii. Social relationships/support; (4-6-05)
- iv. Family; (3-15-02)
- v. Basic living skills; (3-15-02)
- vi. Housing; (3-15-02)
- vii. Community/legal; or (3-15-02)
- viii. Health/medical. (3-15-02)

03. PSR Eligibility Following Discharge from Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsections 450.01.a. for children, and in 450.02.a. for adults, are considered immediately eligible for PSR services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed within ten (10) days of discharge. (4-6-05)

a. Up to two (2) hours of plan development hours may be prior authorized for coordinating with hospital staff and others the participant chooses. These prior authorized plan development hours are to be used for the development of an individualized treatment plan based solely on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment nor does the participant need to qualify as described in Subsection 453.01 of these rules. (4-6-05)

b. Upon submission of the completed individualized treatment plan to the Department or its designee, PSR services may be prior authorized for no more than one hundred twenty (120) days. For services to continue beyond one hundred twenty (120) days, the requirements of Section 452 in these rules must be met by the provider agency. (4-6-05)

04. Place of Service. PSR services are to be home and community-based. (4-6-05)

a. PSR services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is prior authorized. (4-6-05)

b. PSR services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department or its designee to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (4-6-05)

451. RESPONSIBILITIES OF THE DEPARTMENT REGARDING PSR SERVICES.

The Department will administer the provider agreement for the provision of PSR services and is responsible for the following tasks: (4-6-05)

01. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (4-6-05)

02. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements. (5-1-06)T

03. Assessment Authorization. The Department or its designee will review requests for assessment hours and authorize as appropriate. (4-6-05)

04. Individualized Treatment Plan Authorization Requirements. Individualized treatment plan authorizations must include the following: (4-6-05)

- a.** Required Documentation. The required documentation for each individualized treatment plan includes: (4-6-05)
- i. Participant demographic information; (4-6-05)
 - ii. A comprehensive assessment as provided in Subsection 453.01 of these rules; and (4-6-05)
 - iii. A written individualized treatment plan as provided in Subsection 453.02 of these rules. (4-6-05)
 - iv. Adult service plans also require a rehabilitation outcome database. (4-6-05)
 - v. Children's individualized treatment plans also require the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). (4-6-05)
- b.** Physician's Signature and Receipt of Required Documentation. Reimbursement for services will be authorized from the date of the physician's signature if the required documentation is received by the Department or its designee within thirty (30) days from the request of assessment hours. If the documentation is received after thirty (30) days from the date of the request of assessment hours, or after the expiration of the plan, the date to begin services is the date the individualized treatment plan and other required documentation are received by the Department or its designee. For the annual update, all required documentation must be received by the Department or its designee before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the treatment plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 457.05 of these rules. (4-6-05)
- c.** Hours and Type of Service. The Department or its designee must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the individualized treatment plan objectives. (4-6-05)
- d.** Authorization Time Period. Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. (4-6-05)
- e.** No Duplication of Services. The Department or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to PSR participants through other Medicaid reimbursable and non-Medicaid programs. (4-6-05)
- 05. Notice of Decision.** At the point a decision is made that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. (4-6-05)
- 06. Changes in Individualized Treatment Plan Hours or Service Type.** When the Department or its designee is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department or its designee must review the request and either approve or deny within ten (10) working days of receipt. A clear rationale for the change in hours or service type must be included with the request. (4-6-05)
- 07. Changes to Individualized Treatment Plan Objectives.** When a provider believes that an individualized treatment plan needs to be revised, the provider should include that recommendation and rationale in documentation of the next one hundred twenty (120) day review. The Department or its designee will review the information, and if appropriate, act on the recommendation. In the event substantial changes in the participant's mental status or circumstances occur requiring immediate changes in the plan objectives, the provider must notify the Department or its designee, in writing, of its recommendation and rationale for the change. The Department has ten (10) working days to respond to and either approve or deny the request for change. (4-6-05)
- 08. Minor Changes to Individualized Treatment Plan Tasks.** When the Department or its designee is notified in writing by the provider of necessary and specific changes to individualized treatment plan tasks that require no change in total hours or service type, a copy of the amended individualized treatment plan tasks must be

forwarded to the Department or its designee including rationale for those changes. The Department or its designee has ten (10) working days to respond to the changes. If no response is received, the provider may proceed to incorporate those and only those specific task changes into the individualized treatment plan. While task changes may result in reassignment of available hours among tasks, under no circumstances does this permit the provider to increase the total number of prior authorized hours. (4-6-05)

09. Quality of Services. The Department or its designee must monitor the quality and outcomes of PSR services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Family and Community Services. (4-6-05)

452. RESPONSIBILITIES OF PSR PROVIDERS.

01. Provider Agreement. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR services and also is responsible for the following tasks: (4-6-05)

02. Service Provision. Each provider must have a negotiated Supplemental Service Agreement with the Department. (4-6-05)

03. Service Availability. Each provider must assure provision of PSR services to participants on a twenty-four (24) hour basis. (4-6-05)

04. Comprehensive Assessment and Individualized Treatment Plan Development. The provider agency is responsible to conduct a comprehensive assessment and develop an individualized treatment plan for each participant. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs. (4-6-05)

05. Individualized Treatment Plan. The provider must develop an individualized treatment plan in accordance with Subsection 453.02 of these rules. The signature of a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the services are medically necessary. The date of the plan is the date it is signed by the physician if all the required documentation is received by the Department or its designee within thirty (30) days of the date of the request for assessment hours. (4-6-05)

06. Changes to Individualized Treatment Plan Objectives. When a provider believes that an individualized treatment plan needs to be revised, the provider should include that recommendation and rationale in the documentation for the next one hundred twenty (120) day review. (4-6-05)

07. Effectiveness of Services. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review. (4-6-05)

08. Healthy Connections Referral Number. Providers must obtain a Healthy Connections referral number if the participant is enrolled in the Healthy Connections program. (4-6-05)

453. PSR SERVICE DESCRIPTIONS.

The goal of PSR services is to aid participants in work, school, family, community, or other issues related to their mental illness. It is also to aid them in obtaining developmentally appropriate skills for living independently and to prevent movement to a more restrictive living situation. All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives. In order to prevent duplication, PSR services must be coordinated with all other services received by the participant. PSR consists of the following services: (4-6-05)

01. Comprehensive Assessment. A comprehensive assessment must be completed for each participant determined eligible for PSR. The assessment must address the participant's strengths and supports, deficits and needs, and must be directed toward formulation of a diagnosis and a written individualized treatment plan. The participant must take part in the assessment to the fullest extent possible. The assessment must be directly related to the

participant's mental illness and level of functioning. Information regarding services received from any of the participant's service provider(s) must be collected and reported on the comprehensive assessment. The assessment and supplemental psychiatric, psychological, or other specialty evaluations and tests must be written, dated, signed and be retained in the participant's file. The assessment is reimbursable if conducted by qualified provider agency staff listed under Section 456 of these rules. Each of the following areas must be assessed initially and at least annually thereafter: (4-6-05)

- a.** Psychiatric history and current mental status which includes, at a minimum: (4-6-05)
 - i. Diagnosis documented within the last twelve (12) months by a licensed physician or other licensed practitioner of the healing arts, licensed master's level psychiatric nurse, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; (4-6-05)
 - ii. Age of the participant at onset; (4-6-05)
 - iii. Childhood history of physical or sexual abuse; (4-6-05)
 - iv. Number of hospitalizations; (4-6-05)
 - v. Precursors of hospitalizations; (4-6-05)
 - vi. Symptoms of decompensation the participant manifests; (4-6-05)
 - vii. Participant's ability to identify his symptoms; (4-6-05)
 - viii. Medication history; (4-6-05)
 - ix. Substance abuse history; (4-6-05)
 - x. History of mental illness in the family; (4-6-05)
 - xi. Current mental status; and (4-6-05)
 - xii. Any other information that contributes to the assessment of the participant's current psychiatric status. (4-6-05)
- b.** 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 primary physician; (3-15-02)
- c.** 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. For children, this area addresses relevant school enrollment, performance, achievement levels and school-related social functioning; (3-15-02)
- d.** Financial status which includes at a minimum, adequacy and stability of the participant's financial status, financial difficulties of the participant, resources available, and the participant's ability to manage personal finances; (4-6-05)
- e.** Social relationships/support which includes, at a minimum, participant's ability to establish/maintain personal support systems or relationships and participant's ability to develop leisure, recreational, or social interests; (4-6-05)
- f.** Family status which includes, at a minimum, the participant's ability or desire to carry out family roles, participant's perception of the support he receives from his family, and the role the family plays in the participant's mental illness. For children this area addresses the child's functioning within the family and the impact

of the child's mental illness on family functioning; (4-6-05)

g. Basic living skills which include at a minimum, participant's ability to meet age appropriate basic living skills including transition to adulthood; (4-6-05)

h. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, and appropriateness of current living situation with respect to the participant's needs, his health and safety; (4-6-05)

i. Community/Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the participant has in the community, and daily living skills necessary for community living; and (4-6-05)

j. Health or medical issues, or both, including medical complications that result from the mental illness. (4-6-05)

02. Written Individualized Treatment Plan. A written individualized treatment plan must be developed and implemented for each participant of PSR services as a means to address the rehabilitative service needs of the participant. Services must support the goals of PSR which are maximum reduction of mental disability and achievement of the highest possible functioning level for that participant. For adults this means becoming independent or maintaining the highest level of independence. For children this means learning or maintaining developmentally appropriate role functioning. The individualized treatment plan identifies the issue(s), goal(s), areas of need, the objectives and the total number of hours and types of services estimated to achieve all objectives based on the ability of the participant to effectively utilize services. The individualized treatment plan must be developed by the participant, his family, other support systems and the provider agency. Treatment planning is reimbursable if conducted by qualified provider agency staff listed under Section 456 of these rules. The individualized treatment plan must be documented by the provider agency. (4-6-05)

a. An individualized treatment plan must include the following, at a minimum: (4-6-05)

i. An issue statement specifically describing the participant's behavior that directly relates to his mental illness and functional impairment. (4-6-05)

ii. A statement which identifies the participant's goal relative to the goals of PSR as per Section 450 and Subsection 453.02 of these rules; (4-6-05)

iii. Overall goal(s) and concrete, measurable objectives to be achieved, including time frames for completion. At least one (1) objective is required for the focus areas which must likely lead to the greatest stabilizing impact. At a minimum, this should include at least one (1) objective in each of the two (2) focus areas which qualify the participant for PSR; (4-6-05)

iv. Tasks that are specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan and are developed by the participant and the selected provider(s). Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to assist the participant in the completion of tasks. (4-6-05)

v. Documentation of who participated in the development of the individualized treatment plan. The participant, if possible, must take part in the development of the individualized treatment plan. The adult participant or the adult participant's legal guardian must sign the individualized treatment plan or documentation must be provided why this was not possible, including participant refusal to sign. For a minor child participant, the child's parent or legal guardian must sign the plan. A copy of the plan must be given to the adult participant and his legal guardian or to the parent or legal guardian when the participant is a minor child; (4-6-05)

b. An individualized treatment plan must be developed within thirty (30) calendar days from initial face-to-face contact between the provider agency staff and the participant, or the parent or legal guardian when the participant is a minor child. (4-6-05)

c. An individualized treatment plan review by the provider agency staff and the participant must occur at least annually. During the review, the provider agency staff and the participant review any objectives which may be added to or deleted from the individualized treatment plan. Input from other participants in the plan including service provider(s) must be considered. Other attendees of the individualized treatment plan review may be chosen by the adult participant or his legal guardian if any or, when the participant is a minor child, by his family or legal guardian and the provider agency staff. (4-6-05)

d. Each individualized treatment plan must be reviewed and signed by a physician or a licensed practitioner of the healing arts at least annually. Once the date of a plan is established, that date continues to be the annual date of the plan. Any subsequent treatment plans must be received by the Department or its designee on or before the expiration date of the current plan. If a subsequent plan is not received on or before the expiration date of the current plan, services that are provided in the interim will not be reimbursed. (4-6-05)

e. The eligible participant will be allowed to choose whether or not he desires to receive PSR services and who the provider(s) of services will be to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's file showing that the participant has been informed of his rights to refuse services and choose providers. (4-6-05)

03. Pharmacological Management. Pharmacological management services must be provided in accordance with the individualized treatment plan. Pharmacological management, alone, may be provided if the plan indicates that this service is necessary and sufficient to prevent relapse or hospitalization and that functional deficits are either manageable by the participant or absent but expected to return if pharmacological management is not provided. The telephoning of prescriptions to the pharmacy is not a billable service. Medication prescription must be done by a licensed physician or other practitioner of the healing arts within the scope of practice defined in their license in visual contact with the participant. (4-6-05)

04. Individual Psychosocial Rehabilitation (PSR). Individual psychosocial rehabilitation must be provided in accordance with the objectives specified in the individualized treatment plan. Individual PSR is a service provided to an individual participant on a one-to-one basis. Individual PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 456 of these rules. Individual PSR includes one (1) or more of the following: (4-6-05)

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management and other skills related to participant's psychosocial circumstances; (4-6-05)

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors related to the participant's mental illness and to develop interventions with the participant and his employer or teacher; (4-6-05)

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the participant's mental illness; (4-6-05)

d. Problem solving, support, and supervision related to activities of daily living to assist participants in gaining and utilizing skills such as personal hygiene, household tasks, use of transportation, and money management; (4-6-05)

e. Assisting the participant with receiving necessary services when he has difficulty or is unable to obtain them. (4-6-05)

i. This assistance may be given by accompanying him to Medicaid-reimbursable appointments. For reimbursement purposes, the PSR agency staff person must be present during the appointment and deliver a PSR service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable; however, reimbursement is available for the delivery of prior authorized PSR services occurring during these times. (4-6-05)

ii. To be eligible for this service, the participant must have a functional impairment that affects his

ability to communicate accurately due to a mental illness and be unable to report symptoms to a licensed practitioner, as identified in Subsection 456.01, or be unable to understand the practitioner's instructions. The impairment must be identified in the assessment. The individualized treatment plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child; (4-6-05)

f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness and symptom management. (4-6-05)

g. Development of coping skills and symptom management to identify the symptoms of mental illness that are barriers to successful community integration and crisis prevention. (4-6-05)

h. May assist participant with "self" administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. (4-6-05)

05. Group Psychosocial Rehabilitation (PSR). Group PSR must be provided in accordance with the objectives specified in the individualized treatment plan. Group PSR is a service provided to two (2) or more individuals concurrently. Group PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 456 of these rules. This service includes one (1) or more of the following: (4-6-05)

a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness and symptom management. These groups must not be used solely for the purpose of group prescription writing; (4-6-05)

b. Employment or school-related groups to focus on symptom management on the job or in school, symptom reduction, and education about appropriate job or school-related behaviors; (4-6-05)

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (4-6-05)

d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and (3-15-02)

e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (4-6-05)

06. Crisis Intervention Service. Crisis support that includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 456 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or link the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. (4-6-05)

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described

in Subsection 459.03 of these rules. (4-6-05)

b. Crisis Support in an Emergency Department. (4-6-05)

i. A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment. (4-6-05)

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant. (4-6-05)

07. Collateral Contact. Collateral contacts are contacts made with significant individuals in the participant's environment for the purpose of assisting the participant to live in the community. Collateral contacts may include a parent, legal guardian, relatives, family members, landlords, employers, teachers, providers or other individuals with a primary relationship to the participant. The purpose of collateral contacts is to gather and exchange information with individuals specifically identified in the individualized treatment plan. Collateral contacts must be prior authorized. Collateral contact is reimbursable if provided by an agency with a current provider agreement and the agency staff making the contacts meet the qualifications under Section 456 of these rules. Subsection 454.06 of these rules describes limitations on reimbursement for collateral contacts between provider agency staff. The types of collateral contact are as follows: (4-6-05)

a. Collateral contact face-to-face. When two persons meet visually at the same time; (3-15-02)

b. Collateral contact telephone. When it is the most expeditious and effective way to exchange information; and (3-15-02)

c. Collateral contact parent group. When two (2) or more parents of children, under the age of eighteen (18), with similar serious emotional disturbances meet to share information and learn about their children's needs. (3-15-02)

08. Nursing Service. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. This may include supervision, monitoring, and administration of medications. (3-15-02)

09. Psychotherapy. Individual, group and family psychotherapy must be prior authorized and provided in accordance with the objectives specified in the written individualized treatment plan. Staff qualified to deliver psychotherapy and qualified supervisors of psychotherapy are identified in Subsection 469.06 of these rules. Family psychotherapy must include the participant and at least one (1) family member at any given time and must be delivered in accordance with objectives as specified in the written individualized treatment plan. An agency must assure clinical supervision is available to all staff that provide psychotherapy. The amount of supervision should be adequate to insure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (4-6-05)

10. Occupational Therapy. Occupational therapy services must be prior authorized by the Department or its designee, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections 456.12 and 458.08 of these rules. (4-6-05)

454. EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID PSR.

Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (4-6-05)

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 458.09 of these rules; (4-6-05)

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose; (3-15-02)

03. Employment. Job-specific interventions, job training and job placement services which includes

helping the participant develop a resume, applying for a job, and job training or coaching; (4-6-05)

04. Household Tasks. Staff performance of household tasks and chores; (3-15-02)

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant; (4-6-05)

06. Client Staffing Within an Agency. A client staffing between two (2) staff who both provide PSR services within the same agency is not reimbursable. A client staffing may fall under the definition of collateral contact when it is prior authorized and occurs between two (2) staff who are providing services from different Medicaid programs either within or outside the same agency. (4-6-05)

07. Medication Drops. Delivery of medication only; (3-15-02)

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan; and (4-6-05)

09. Transportation. The provision of transportation services and staff time to transport. (4-6-05)

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009; (4-6-05)

11. Services Not Listed. Any other services not listed in Section 453 of these rules. (4-6-05)

455. PSR PROVIDER AGENCY REQUIREMENTS.

Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements: (4-6-05)

01. Agency. A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 456 of these rules, and offering both PSR services and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll. (4-6-05)

02. Credentialing. The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place. (5-1-06)T

a. Reimbursement. A PSR agency must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated. (5-1-06)T

b. Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department or its designee. All initial applications will be responded to within thirty (30) days indicating if the application is approved or additional information is required. The applicant must submit the additional information for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal then the application will be denied and the application will not be considered again for twelve (12) months. (5-1-06)T

c. Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers not to exceed three (3) years. (5-1-06)T

d. New Providers. Once the Credentialing Program is initiated any new provider applicants will be required to submit an application and successfully complete the credentialing process prior to billing for Medicaid services. (5-1-06)T

e. Elements of Credentialing. The credentialing process consists of the application and an on-site

review. Whenever deficiencies are identified a plan of improvement approved by the Department or its designee must be submitted by the agency. (5-1-06)T

f. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless sooner suspended or revoked, the agency's credential will expire on the date designated by the Department or its designee. No later than ninety (90) days before expiration, an agency may apply for renewal of credentials. A site review may be conducted by the Department or its designee for renewal applications. (5-1-06)T

g. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred and eighty (180) days. During that time, the Department or its designee will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (5-1-06)T

h. Denial, or Revocation of Credentialed Status. The Department or its designee may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (5-1-06)T

i. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (5-1-06)T

ii. The provider agency or provider agency applicant has been convicted of a criminal offense related to the provider's or applicant's involvement in any program established under Medicare, Medicaid or the Title XX Services Program, or has been found to have committed any offense involving theft, or abuse, neglect or exploitation of another person; (5-1-06)T

iii. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; (5-1-06)T

iv. The provider agency or provider agency applicant has been denied or has had revoked any health facility license, or certificate; (5-1-06)T

v. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (5-1-06)T

vi. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (5-1-06)T

vii. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 455.02.h.i. through 455.02.h.vi. of these rules. (5-1-06)T

i. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department or the Department's designee will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (5-1-06)T

03. Criminal History Checks. (4-6-05)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (4-6-05)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (4-6-05)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction. (4-6-05)

04. PSR Agency Staff Qualifications. The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 456 of these rules. (4-6-05)

05. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (4-6-05)

06. Supervision. The agency must provide staff with adequate supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Individuals in Subsections 456.09 through 456.12 of these rules must be supervised by individuals in Subsections 456.01 through 456.08. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (4-6-05)

07. Continuing Education. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (4-6-05)

08. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (4-6-05)

09. Ethics. (2-1-05)T

a. The provider must adopt, adhere to and enforce among its staff who are providing Medicaid reimbursable services a Code of Ethics similar to or patterned after one (1) of the following: (5-1-06)T

i. US Psychiatric Rehabilitation Association Code of Ethics found at <http://www.uspra.org/i4a/pages/index.cfm?pageid=3601>; (5-1-06)T

ii. National Association of Social Workers Code of Ethics found at <http://www.naswdc.org/pubs/code/default.asp>; (5-1-06)T

iii. American Psychological Association Code of Ethics found at <http://www.apa.org/ethics/code.html>; or (5-1-06)T

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Content/NavigationMenu/RESOURCES/ETHICS/ACA_Code_of_Ethics.htm (5-1-06)T

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrmp/ethics/ethicscode2001.asp. (5-1-06)T

b. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the code must be submitted to the Department or its designee upon request. (5-1-06)T

c. The Provider must develop a schedule for providing ethics training to its staff. (5-1-06)T

d. The ethics training schedule must provide that new employees receive the training during their first

year of employment, and that all staff receive ethics training no less than four hours every four (4) years thereafter. (5-1-06)T

456. PSR AGENCY STAFF QUALIFICATIONS.

All agency staff delivering PSR services must meet at least one (1) of the following qualifications: (4-6-05)

01. Licensed Physician or Psychiatrist. A physician, psychiatrist, or other licensed practitioners of the healing arts within the scope of his practice under state law must be licensed in accordance with Title 54, Chapter 18, Idaho Code, to practice medicine. A licensed practitioner of the healing arts in Idaho may include Physician Assistants and Nurse Practitioners; (4-6-05)

02. Licensed Master's Level Psychiatric Nurse. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; (4-6-05)

03. Licensed Psychologist. A psychologist must be licensed in accordance with Title 54, Chapter 23, Idaho Code; (4-6-05)

04. Licensed Clinical Professional Counselor or Licensed Professional Counselor. A clinical professional counselor or professional counselor must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (4-6-05)

05. Licensed Marriage and Family Therapist. A marriage and family therapist must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (4-6-05)

06. Licensed Masters Social Worker or Licensed Clinical Social Worker. A masters social worker (LMSW) or clinical social worker (LCSW), must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (4-6-05)

07. Clinician. A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho State Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources; (4-6-05)

08. Licensed Pastoral Counselor. A pastoral counselor must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists". Training and experience in a mental health setting are required; (4-6-05)

09. Licensed Social Worker. A social worker must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (4-6-05)

10. Licensed Professional Nurse (RN). A licensed professional nurse or RN, must be licensed in accordance with Title 54, Chapter 14, Idaho Code; (4-6-05)

11. Psychosocial Rehabilitation (PSR) Specialist. A PSR specialist must hold at least a bachelor's degree from a nationally accredited university or college in behavioral science education, or medicine. A PSR specialist must have at least twenty-one (21) semester credit hours (or quarter hour equivalent) in human service fields such as psychology, social work, special education, counseling, and psychosocial rehabilitation. An individual who has been denied licensure, or who is qualified to apply for licensure to the State of Idaho, Bureau of Occupational Licenses in the professions identified in Subsections 456.01 through 456.10 of this rule, is not eligible to provide services under the designation of Psychosocial Rehabilitation Specialist. Individuals approved as PSR specialists under previous rules in this section will be able to continue as qualified PSR specialists as long as they continue to work in the same agency as they did prior to the effective date of this rule; or (4-6-05)

12. Licensed Occupational Therapist. An occupational therapist must be licensed in accordance with Title 54, Chapter 37, Idaho Code, and IDAPA 22.01.09, "Rules for the Licensing of Occupational Therapists and

Occupational Therapist Assistants". Training and experience in a mental health setting are required. (4-6-05)

13. Psychologist Extender. A psychologist extender must work under the supervision of a licensed psychologist and be registered with the Bureau of Occupational Licenses. A copy of that registration must be retained in the extender's personnel file. (4-6-05)

457. RECORD REQUIREMENTS FOR PSR PROVIDERS.

In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (4-6-05)

01. Name. Name of participant; (4-6-05)

02. Provider. Name of the provider agency and the agency staff person delivering the service; (4-6-05)

03. Date, Time, Duration of Service, and Justification. Date, time, and duration of services. Documentation must justify the length of time which is billed; (3-15-02)

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant; (4-6-05)

05. One Hundred Twenty Day Review. A documented review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. For children, a copy of the review must be sent to the Department or its designee within five (5) working days of the due date. For adults, a copy of the review must be sent to the Department or its designee upon request. Failure to do so may result in the loss of a prior authorization or result in a recoupment of reimbursement provided for services delivered after the one hundred twenty (120) day review due date. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring functional impairment. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services; (4-6-05)

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service; and (4-6-05)

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (4-6-05)

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department or its designee identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (4-6-05)

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period. (4-6-05)

458. PAYMENT FOR PSR SERVICES.

Payment for PSR services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (4-6-05)

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (4-6-05)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment,

individualized treatment plan, or case review when multiple PSR staff are present. (4-6-05)

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18 Idaho Code. (3-15-02)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (4-6-05)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (4-6-05)

06. Evaluations and Tests. Evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (3-15-02)

07. Psychological Evaluations. Psychological evaluations are reimbursable if provided in accordance with the requirements in Subsection 468.06 of these rules. (4-6-05)

08. Evaluations by Occupational Therapists. Evaluations performed by qualified licensed occupational therapists, performed in conjunction with development of an individualized treatment plan are reimbursable. (4-6-05)

09. Psychiatric or Medical Inpatient Stays. 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 inpatient facility. Treatment services are the responsibility of the facility. (4-6-05)

459. PSR SERVICE LIMITATIONS.

The following service limitations apply to PSR services, unless otherwise authorized by the Department or its designee in each region. (4-6-05)

01. Assessment and Individualized Treatment Plan Development. Any combination of evaluations or diagnostic services is limited to a maximum of six (6) hours annually. Additional hours may be approved by the Department or its designee under the following situations: (4-6-05)

a. When the participant selects more than one (1) provider. (4-6-05)

b. When individualized treatment plan development is being done by an agency that did not do the assessment. (4-6-05)

02. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (3-30-01)

03. Crisis Intervention Service. A maximum of twenty (20) hours of crisis support in a community may be reimbursed per crisis during any consecutive five (5) day period. Authorization must follow procedure described above at Subsection 453.06 of these rules. (4-6-05)

04. Psychosocial Rehabilitation. Individual and group PSR services are not to exceed twenty (20) hours per week and must receive prior authorization from the Department or its designee. Services in excess of twenty (20) hours require additional review and prior authorization by the Department or its designee in each region. The prior authorization of additional hours must be documented in the individualized treatment plan and written approval must be retained in the participant's file. (4-6-05)

460. BUILDING STANDARDS FOR PSR AGENCY LOCATIONS.

Each physical location that is maintained by the PSR agency and where participants go to meet or receive services must meet the following standards: (5-1-06)T

01. Accessibility. PSR service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (5-1-06)T

02. Environment. PSR agency offices must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (5-1-06)T

03. Capacity. PSR agency offices must provide qualified staff as listed in Subsection 465.07 of these rules to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. (5-1-06)T

04. Fire and Safety Standards. (5-1-06)T

a. PSR agency offices must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (5-1-06)T

b. PSR agency offices must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (5-1-06)T

c. In PSR agency offices where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (5-1-06)T

d. PSR agency offices must be kept free from the accumulation of weeds, trash and rubbish; and (5-1-06)T

e. Portable heating devices are prohibited except units that have heating elements that are limited to not more than 212°F. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (5-1-06)T

f. Flammable or combustible materials must not be stored in the PSR agency; and (5-1-06)T

g. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (5-1-06)T

h. Water temperatures in areas accessed by participants must not exceed 120°F; and (5-1-06)T

i. Portable fire extinguishers must be installed throughout the agency facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 472.04 of these rules; and (5-1-06)T

j. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (5-1-06)T

k. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (5-1-06)T

l. Furnishings, decorations or other objects must not obstruct exits or access to exits. (5-1-06)T

05. Emergency Plans and Training Requirements. (5-1-06)T

a. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation,

location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building.(5-1-06)T

b. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (5-1-06)T

c. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (5-1-06)T

d. All employees and PSR participants who receive services at that location must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (5-1-06)T

e. A brief summary of the fire drill and the response of the employees and participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (5-1-06)T

06. Food Preparation and Storage. (5-1-06)T

a. If foods are prepared in the PSR agency offices, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (5-1-06)T

b. Except during actual preparation time, cold perishable foods must be stored and served under 45°F and hot perishable foods must be stored and served over 140°F. (5-1-06)T

c. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at 45°F or below. Freezers must be maintained at 0°F to 10°F or below. (5-1-06)T

d. When meals are prepared or provided for by the PSR agency for participants, meals must be nutritional. (5-1-06)T

07. Housekeeping and Maintenance Services. (5-1-06)T

a. The interior and exterior of the PSR offices must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (5-1-06)T

b. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (5-1-06)T

c. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (5-1-06)T

d. The PSR agency must be maintained free from infestations of insects, rodents and other pests; and (5-1-06)T

e. The PSR agency must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (5-1-06)T

f. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (5-1-06)T

08. Firearms. No firearms are permitted in the PSR agency offices. (5-1-06)T

09. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the PSR agency offices in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (5-1-06)T

10. Lighting. Lighting levels must be maintained throughout the PSR agency offices which are

appropriate to the service being provided.

(5-1-06)T

11. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department.

(5-1-06)T

461. 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.

(5-1-06)T

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 16.03.10, Section 406, "Rules Governing Medicaid Provider Reimbursement in Idaho".

(12-31-91)

462. -- 463. (RESERVED).

464. CLINIC SERVICES -- MENTAL HEALTH CLINICS (MHC).

Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under Subsection 469.05.a.

(4-6-05)

465. MENTAL HEALTH CLINIC PROVIDER AGENCY REQUIREMENTS.

Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements:

(4-6-05)

01. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. The Department must approve the enrollment of the agency as a Medicaid provider. Each location of the agency must meet these requirements. All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual.

(4-6-05)

02. Credentialing. The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place.

(5-1-06)T

a. Reimbursement. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated.

(5-1-06)T

b. Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department or its designee. All initial applications will be responded to within thirty (30) days

indicating if the application is approved or additional information is required. The applicant must submit the additional information for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal then the application will be denied and the application will not be considered again for twelve (12) months. (5-1-06)T

c. Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers not to exceed three (3) years. (5-1-06)T

d. New Providers. Once the Credentialing Program is initiated any new provider applicants will be required to submit an application and successfully complete the credentialing process prior to billing for Medicaid services. (5-1-06)T

e. Elements of Credentialing. The credentialing process consists of the application and an on-site review. Whenever deficiencies are identified a plan of improvement approved by the Department or its designee must be submitted by the agency. (5-1-06)T

f. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless sooner suspended or revoked, the agency's credential will expire on the date designated by the Department or its designee. No later than ninety (90) days before expiration, an agency may apply for renewal of credentials. A site review may be conducted by the Department or its designee for renewal applications. (5-1-06)T

g. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred and eighty (180) days. During that time, the Department or its designee will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (5-1-06)T

h. Denial, or Revocation of Credentialed Status. The Department or its designee may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (5-1-06)T

i. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (5-1-06)T

ii. The provider agency or provider agency applicant has been convicted of, or is currently under investigation for fraud, gross negligence, abuse, assault, battery or exploitation; (5-1-06)T

iii. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; (5-1-06)T

iv. The provider agency or provider agency applicant has been denied or has had revoked any health facility license, or certificate; (5-1-06)T

v. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (5-1-06)T

vi. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (5-1-06)T

vii. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 465.02.h.i. through 465.02.h.vi. of these rules. (5-1-06)T

i. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department or the Department's designee will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (5-1-06)T

03. Physician Requirement for Clinic Supervision. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician. (4-6-05)

a. The contract must specifically require that the physician spend as much time in the facility as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice. (4-6-05)

b. The supervising physician of the clinic may also serve as the supervising physician of a participant's care. (4-6-05)

04. Physician Requirement for Supervision of a Participant's Care. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met: (4-6-05)

a. The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided; (4-6-05)

b. The physician must see the participant at least once to determine the medical necessity and appropriateness of clinic services; (4-6-05)

c. The physician must review and sign the individualized treatment plan as an indicator that the services are prescribed; and (4-6-05)

d. The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services. (4-6-05)

05. Assessment. All treatment in mental health clinics must be based on an individualized assessment of the patient's needs, including a current mental status examination, and provided under the direction of a licensed physician. (4-6-05)

06. Criminal History Checks. (4-6-05)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (4-6-05)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (4-6-05)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department or its designee when the agency learns of the conviction. (4-6-05)

07. Staff Qualifications. The mental health clinic must assure that each agency staff person delivering clinical services to eligible MA participants has, at a minimum, one (1) or more of the following qualifications:

- (4-6-05)
- a. Licensed Psychiatrist; (4-6-05)
 - b. Licensed Physician or licensed practitioner of the healing arts; (4-6-05)
 - c. Licensed Psychologist; (4-6-05)
 - d. Psychologist extender, registered with the Bureau of Occupational Licenses; (4-6-05)
 - e. Licensed Masters Social Worker, Licensed Clinical Social Worker, or Licensed Social Worker; (4-6-05)
 - f. Licensed Clinical Professional Counselor or Licensed Professional Counselor; (4-6-05)
 - g. Licensed Marriage and Family Therapist; (4-6-05)
 - h. Certified Psychiatric Nurse, R.N., as described in Subsection 456.02 of these rules; (4-6-05)
 - i. Licensed Professional Nurse, R.N.; or (4-6-05)
 - j. Registered Occupational Therapist, O.T.R. (4-6-05)

08. Support Staff. For the purposes of this rule, support staff is any person who does not meet the qualifications of professionals as listed in Subsection 465.07 of these rules. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid. (5-1-06)T

09. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (4-6-05)

10. Supervision. The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (4-6-05)

- a. Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (4-6-05)
- b. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (4-6-05)
- c. Documentation of supervision must be maintained by the agency and be available for review by the Department or its designee. (4-6-05)

11. Continuing Education. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department or its designee. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (4-6-05)

12. Informed Consent. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian. (4-6-05)

13. Ethics. (2-1-05)T

a. The provider must adopt, adhere to and enforce among its staff who are providing Medicaid reimbursable services a Code of Ethics similar to or patterned after one (1) of the following: (5-1-06)T

i. US Psychiatric Rehabilitation Association Code of Ethics found at <http://www.uspra.org/i4a/pages/index.cfm?pageid=3601>; (5-1-06)T

ii. National Association of Social Workers Code of Ethics found at <http://www.naswdc.org/pubs/code/default.asp>; (5-1-06)T

iii. American Psychological Association Code of Ethics found at <http://www.apa.org/ethics/code.html>; or (5-1-06)T

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Content/NavigationMenu/RESOURCES/ETHICS/ACA_Code_of_Ethics.htm. (5-1-06)T

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/Irmplan/ethics/ethicscode2001.asp. (5-1-06)T

b. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the code must be submitted to the Department or its designee upon request. (5-1-06)T

c. The Provider must develop a schedule for providing ethics training to its staff. (5-1-06)T

d. The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter. (5-1-06)T

466. INDIVIDUALIZED TREATMENT PLAN FOR MENTAL HEALTH CLINIC SERVICES.

A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 465.07 of these rules. (5-1-06)T

01. Individualized Treatment Plan Development. The individualized treatment plan must be developed by the following: (4-6-05)

a. The clinic staff providing the services; and (4-6-05)

b. The adult participant, if capable, and the adult participant's legal guardian, or, in the case of a minor, the minor's parent or legal guardian. The participant or his parent or legal guardian may also choose others to participate in the development of the plan. (4-6-05)

02. Individualized Treatment Plan Requirements. An individualized treatment plan must include the following, at a minimum: (4-6-05)

a. Statement of the overall goals and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized and must be directly related to the clinic service needs that are identified in the assessment. (4-6-05)

b. Documentation of who participated in the development of the individualized treatment plan. (4-6-05)

i. The authorizing physician must sign and date the plan within (30) thirty calendar days from the initiation of treatment. (4-6-05)

ii. The adult participant, the adult participant's legal guardian or, in the case of a minor, the minor's parent or legal guardian, must sign the treatment plan indicating their participation in its development. If these

signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the adult participant and his legal guardian or to his parent or legal guardian if the participant is a minor. (4-6-05)

iii. Other individuals who participated in the development of the treatment plan must sign the plan. (4-6-05)

iv. The author of the treatment plan must sign the plan and include his title and credentials. (4-6-05)

c. The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; and (4-6-05)

d. A problem list, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services. (4-6-05)

03. Treatment Plan Review. The treatment plan review by the clinic and the participant must occur within one-hundred-twenty (120) days and every one-hundred-twenty (120) days thereafter. During the review, the clinic staff providing the services and the participant must review progress made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the adult participant or his legal guardian, or, in the case of a minor, his parent or legal guardian and clinic staff providing the services. (4-6-05)

04. Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan. (4-6-05)

05. Authorization for Services. Authorization for services after the first year must be based on documentation of the following: (4-6-05)

a. Description of the ways the participant has specifically benefited from clinic services, and why he continues to need additional clinical services; and (4-6-05)

b. The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue. (4-6-05)

467. CARE AND SERVICES IN MENTAL HEALTH CLINICS NOT REIMBURSED.

01. Inpatient Medical Facilities. The MA Program will not pay for mental health clinic services rendered to MA recipients residing in inpatient medical facilities including nursing homes, hospitals, or public institutions as defined in 42 CFR 435.1009; or (4-6-05)

02. Scope. Any service or supplies not included as part of the allowable scope of the MA Program; or (3-30-01)

03. Non-Qualified Persons. Services provided within the mental health clinic framework by persons other than those qualified to deliver services as specified in Subsection 465.07 of these rules. (5-1-06)T

468. EVALUATION AND DIAGNOSTIC SERVICES IN MENTAL HEALTH CLINICS.

01. Medical Psychosocial Histories. Medical psychosocial intake histories must be contained in all case files. (3-30-01)

02. Diagnosis and Individualized Treatment Plan. Information gathered will be used for establishing

a participant data base used in part to formulate the diagnosis and individualized treatment plan. (4-6-05)

03. Qualified Therapist. The medical psychosocial intake and plan development is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following qualifications: (3-30-01)

- a. Licensed Psychologist; or (7-1-99)
- b. Psychologist extender, registered with the Bureau of Occupational Licenses; or (7-1-99)
- c. Licensed Masters Social Worker, or Licensed Clinical Social Worker, or Licensed Social Worker; or (4-6-05)
- or
- d. Certified Psychiatric Nurse, R.N.; or (7-1-99)
- e. Licensed Clinical Professional Counselor or Licensed Professional Counselor; or (4-6-05)
- f. Licensed Physician or Licensed Psychiatrist; or (4-6-05)
- g. Licensed Marriage and Family Therapist; or (3-15-02)
- h. Licensed Professional Nurse (RN). (4-6-05)

04. Intake Assessment. 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 468.03 of these rules, and later becomes eligible for MA, a new intake assessment and individualized treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. (4-6-05)

05. Non-Qualified Staff. Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Section 468 or Sections 466 or 469 of these rules, is not eligible for reimbursement under the MA Program. (4-6-05)

06. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (4-6-05)

a. Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. (4-6-05)

b. The psychological report must contain the reason for the performance of this service. (4-6-05)

c. Agency staff may deliver this service if they meet one (1) of the following qualifications: (4-6-05)

i. Licensed Psychologist; (4-6-05)

ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or (4-6-05)

iii. A qualified therapist listed in Subsection 469.06 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. (4-6-05)

07. Psychiatric Diagnostic Interview Exam. A psychiatric diagnostic interview exam may be provided as a reimbursable service when delivered by one (1) of the following licensed professionals: (4-6-05)

a. Psychiatrist; (4-6-05)

- b.** Physician; (4-6-05)
- c.** Practitioner of the healing arts; (4-6-05)
- d.** Psychologist; (4-6-05)
- e.** Clinical social worker; (5-1-06)T
- f.** Clinical professional counselor; or (5-1-06)T
- g.** Licensed Marriage and Family Therapist. (5-1-06)T

08. Evaluations Performed by Occupational Therapists. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of an individualized treatment plan are reimbursable. (4-6-05)

09. Documentation. 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 participant's file for documentation purposes. (4-6-05)

10. Data. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (4-6-05)

11. Limitations. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year. (4-6-05)

469. TREATMENT SERVICES IN MENTAL HEALTH CLINICS.

01. Psychotherapy. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan. (4-6-05)

02. Family Psychotherapy. Family psychotherapy services must include at least two (2) family members and must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. (4-6-05)

03. Emergency Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (3-30-01)

a. Emergency services provided to an eligible participant prior to intake and evaluation is a reimbursable service but must be fully documented in the participant's record; and (4-6-05)

b. Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations in accordance with Subsections 469.06 and 469.07 of these rules even when contact does not result in the hospitalization of the participant. (4-6-05)

04. Collateral/Contact Consultation. Collateral contact will be covered by Medicaid if it is conducted face to face by agency staff qualified to deliver clinical services, and if it is included on the individualized treatment plan and is necessary to gather and exchange information with individuals having a primary relationship to the participant. (4-6-05)

05. Nursing Facility. Psychotherapy services may be provided to participants residing in a nursing facility if the following criteria are met: (4-6-05)

- a. The participant has been identified through the PASARR Level II screening process as requiring psychotherapy as a specialized service; and (4-6-05)
 - b. The service is provided outside the nursing facility at a clinic location; and (3-30-01)
 - c. Services provided are: (11-29-91)
 - i. Supported by the independent evaluations completed and approved by the Department or its designee; and (4-6-05)
 - ii. Incorporated into the participant's medical care plan; and (4-6-05)
 - iii. Directed toward the achievement of specific measurable objectives which include target dates for completion. (11-29-91)

06. Staff Qualifications for Psychotherapy Services. Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 469.01 through 469.03 of these rules must have, at a minimum, one (1) or more of the following degrees: (4-6-05)

- a. Licensed Psychiatrist; or (4-6-05)
 - b. Licensed Physician; or (4-6-05)
 - c. Licensed Psychologist; or (7-1-99)
 - d. Licensed Clinical Social Worker; or (4-6-05)
 - e. Licensed Clinical Professional Counselor; or (4-6-05)
 - f. Licensed Marriage and Family Therapist; or (4-6-05)
 - g. Certified Psychiatric Nurse (RN), as described in Subsection 456.02 of these rules; or (4-6-05)
 - h. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 469.06.a. through 469.06.g. of this rule; or (4-6-05)
 - i. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (4-6-05)
 - j. A Psychologist Extender, registered with the Bureau of Occupational Licenses. (4-6-05)

07. Psychotherapy Limitations. Psychotherapy services as set forth in Subsections 469.01 through 469.03 of these rules are limited to forty-five (45) hours per calendar year. (3-15-02)

08. Pharmacological Management. Pharmacological management consultations must be provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (4-6-05)

- a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the individualized treatment plan; and (4-6-05)
 - b. Pharmacological management, if provided, must be part of the individualized treatment plan and frequency and duration of the treatment must be specified. (4-6-05)

09. Nursing Services. Nursing services, when physician ordered and supervised, can be part of the participant's individualized treatment plan. (4-6-05)

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (4-6-05)

b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (4-6-05)

10. Partial Care. Partial Care is treatment for those whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial Care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. The goal of Partial Care services is to decrease the severity and acuity of presenting symptoms so that the program participant may be maintained in the least restrictive setting and to increase the program participants' interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (4-6-05)

a. Qualifications of Partial Care Services. In order to be considered a Partial Care service, the service must: (4-6-05)

i. Be provided in a structured environment within the MHC setting; (4-6-05)

ii. Be a needed service as indicated on the individualized treatment plan with documented, concrete, and measurable goals and outcomes; and (4-6-05)

iii. Provide interventions for relieving symptoms and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (4-6-05)

b. Limit on Treatment Hours. Treatment will be limited to thirty-six (36) hours per week per eligible participant. (4-6-05)

c. Criteria for Partial Care Service Program Participants. In order for a MHC program participant to be eligible for Partial Care Services the following criteria must be met and documented: (4-6-05)

i. Assessments completed within the previous twelve (12) months have documented that the participant has any combination of emotional, behavioral, neurobiological or substance abuse problems that significantly impair social and occupational functioning. The intake assessment must document that the participant is presently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning. (4-6-05)

ii. Other services have failed or are not appropriate for the clinical needs of the participant. (4-6-05)

iii. For each participant, the services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-6-05)

d. Partial care service is not appropriate for certain people. Persons identified in the list below are disqualified from participating in Partial Care services: (4-6-05)

i. Persons at immediate risk of self-harm or harm to others; (4-6-05)

ii. Persons needing more restrictive care or inpatient care; and (4-6-05)

iii. Persons who have not fulfilled the requirements of Subsection 469.10.c. of this rule. (4-6-05)

e. Partial Care Services Must Be on the Individualized Treatment Plan. Partial care services must be part of the participant's individualized treatment plan which must identify the specific objective to be addressed through the service and specify the amount, frequency, and expected duration of treatment. (4-6-05)

f. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in Subsection 465.07 of these rules. (5-1-06)T

g. Excluded Services. Services that focus on vocation, recreation or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. (4-6-05)

470. RECORD KEEPING REQUIREMENTS FOR MENTAL HEALTH CLINICS.

01. Maintenance. Each mental health clinic will be required to maintain records on all services provided to MA participants. (4-6-05)

02. Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 466. (4-6-05)

03. Requirements. The records must: (3-30-01)

a. Specify the exact type of treatment provided; and (11-10-81)

b. Who the treatment was provided by; and (11-10-81)

c. Specify the duration of the treatment and the time of day delivered; and (4-6-05)

d. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and (4-6-05)

e. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (11-10-81)

04. Non-Reimbursable. Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (4-6-05)

05. Non-Eligible Staff. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 465.07 of these rules is not be eligible for reimbursement by the Department. (5-1-06)T

06. Recoupment. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the participant are subject to recoupment. (4-6-05)

471. PAYMENT PROCEDURES.

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

02. Payment in Full. Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the MA recipient for any portion of any charges incurred for the cost of his care. (3-30-01)

03. Third Party. All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payers will be required by the Department. (3-30-01)

04. Injections. Payment for the administration of injections must be in accordance with rates established by the Department. (3-30-01)

472. BUILDING STANDARDS FOR MENTAL HEALTH CLINICS.

01. Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (4-6-05)

02. Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (4-6-05)

03. Capacity. Clinics must provide qualified staff as listed in Subsection 465.07 of these rules to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. (5-1-06)T

04. Fire and Safety Standards. (4-6-05)

a. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (4-6-05)

b. The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (4-6-05)

c. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (4-6-05)

d. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (4-6-05)

e. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (4-6-05)

f. Flammable or combustible materials must not be stored in the clinic facility; and (4-6-05)

g. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (4-6-05)

h. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (4-6-05)

i. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 472.04 of these rules; and (4-6-05)

j. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (4-6-05)

k. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (4-6-05)

l. Furnishings, decorations or other objects must not obstruct exits or access to exits. (4-6-05)

05. Emergency Plans and Training Requirements. (4-6-05)

a. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (4-6-05)

b. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (4-6-05)

c. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (4-6-05)

d. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (4-6-05)

e. A brief summary of the fire drill and the response of the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (4-6-05)

06. Food Preparation and Storage. (4-6-05)

a. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (4-6-05)

b. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. (4-6-05)

c. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (4-6-05)

d. When meals are prepared or provided for by the clinic, meals must be nutritional. (4-6-05)

07. Housekeeping and Maintenance Services. (4-6-05)

a. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (4-6-05)

b. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (4-6-05)

c. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (4-6-05)

d. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (4-6-05)

e. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (4-6-05)

f. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (4-6-05)

08. Firearms. No firearms are permitted in the clinic facility. (4-6-05)

09. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands. (4-6-05)

10. Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided. (4-6-05)

11. Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department. (4-6-05)

473. -- 475. (RESERVED).

476. SERVICE COORDINATION FOR THE MENTALLY ILL.

The Department will purchase service coordination services, as described in IDAPA 16.03.17, "Service Coordination," for adult Medicaid recipients with severe disabling mental illness. Services will be provided by an organized provider agency that 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. (4-6-05)

477. -- 499. (RESERVED).

500. 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). (7-1-99)

501. PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NF CARE AND SERVICES.

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 483 Subpart C and Section 1919(e) (7) of the Social Security Act. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the Regional Medicaid Unit (RMU) will not be earlier than the date the Level II screen is completed, indicating that NF placement is appropriate. (3-15-02)

502. INFORMATION REQUIRED FOR DETERMINATION - MEDICAL EVALUATION.

A current Minimum Data Set (MDS) assessment will be provided to the Department. Additional supporting information may be requested. (3-15-02)

503. -- 504. (RESERVED).

505. INFORMATION REQUIRED FOR DETERMINATION - LEVEL I AND II SCREENS.

An accurate Level I screen and, when required, a Level II screen. (7-1-99)

506. CRITERIA FOR DETERMINING NEED FOR NF CARE.

The recipient requires NF level of care when an adult meets or exceeds the functional level described in Subsection 506.06, or when a child meets one (1) or more of the criteria described in Subsections 506.07, 506.08, 506.09 or 506.10. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years. (3-15-02)

01. Required Assessment, Adults. A standard assessment will be administered by the Department or its designee to all adults requesting services with requirements for Nursing Facility (NF) level of care. The Department will specify the instrument to be used. (3-30-01)

02. Functional Level, Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its designee. In determining need for NF care an adult must require the level of assistance listed in Subsections 506.03 through 506.05, according to the formula described in Subsection 506.06: (3-15-02)

03. Critical Indicator (Twelve (12) Points Each). (3-30-01)

- a. Total assistance with preparing or eating meals. (3-15-02)
- b. Total or extensive assistance in toileting. (3-30-01)
- c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (3-30-01)
- 04. High Indicator (Six (6) Points Each).** (3-30-01)
 - a. Extensive assistance with preparing or eating meals. (3-15-02)
 - b. Total or extensive assistance with routine medications. (3-30-01)
 - c. Total, extensive or moderate assistance with transferring. (3-30-01)
 - d. Total or extensive assistance with mobility. (3-30-01)
 - e. Total or extensive assistance with personal hygiene. (3-30-01)
 - f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (3-30-01)
- 05. Medium Indicator (Three (3) points each).** (3-30-01)
 - a. Moderate assistance with personal hygiene. (3-30-01)
 - b. Moderate assistance with preparing or eating meals. (3-15-02)
 - c. Moderate assistance with mobility. (3-30-01)
 - d. Moderate assistance with medications. (3-30-01)
 - e. Moderate assistance with toileting. (3-30-01)
 - f. Total, extensive, or moderate assistance with dressing. (3-30-01)
 - g. Total, extensive or moderate assistance with bathing. (3-30-01)
 - h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (3-20-04)
- 06. NF Level of Care, Adults.** In order to qualify for NF level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (3-15-02)
 - a. One (1) or more critical indicators = Twelve (12) points (3-30-01)
 - b. Two (2) or more high indicators = Twelve (12) points (3-30-01)
 - c. One (1) high and two (2) medium indicators = Twelve (12) points (3-30-01)
 - d. Four (4) or more medium indicators = Twelve (12) points (3-30-01)
- 07. Supervision Required, Children.** Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-30-01)
- 08. Preventing Deterioration, Children.** Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child,

even where full recovery or medical improvement is not possible. (3-30-01)

09. Specific Needs, Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-30-01)

10. NF Level of Care, Children. Using the criteria found in Subsections 506.07, 506.08, and 506.09, plus consideration of the developmental milestones, based on the age of the child, the Department's RMU will determine NF level of care. (3-30-01)

507. SKILLED SERVICES.

Skilled services include services which could qualify as either skilled nursing or skilled rehabilitative services, which include: (7-1-99)

01. Oversight. 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. (7-1-99)

02. Assessment. 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. (7-1-99)

03. Direct Skilled Nursing Services. Services which qualify as direct skilled nursing services include the following: (7-1-99)

a. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; and (7-1-99)

b. Nasopharyngeal feedings; and (7-1-99)

c. Nasopharyngeal and tracheotomy aspiration; and (7-1-99)

d. Insertion and sterile irrigation and replacement of catheters; and (7-1-99)

e. Application of dressings involving prescription medications and/or aseptic techniques; and (7-1-99)

f. Treatment of extensive decubitus ulcers or other widespread skin disorders; and (7-1-99)

g. 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 (7-1-99)

h. Initial phases of a regimen involving administration of oxygen. (7-1-99)

04. Direct Skilled Rehabilitative Services. Services which qualify as direct skilled rehabilitative services include the following: (7-1-99)

a. Assessment. 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 (7-1-99)

b. Therapeutic exercise. 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 (7-1-99)

c. Evaluation and training. 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 (7-1-99)

d. Ultrasound, short-wave, and microwave therapies. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist; and (7-1-99)

e. Other treatment and modalities. 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. (7-1-99)

508. -- 520. (RESERVED).

521. UTILIZATION CONTROL REVIEWS.

Selection of participants to be reviewed at least annually: (4-6-05)

01. Level II Participants. Participants who have a Level II evaluation, with the review completed within the quarter of the admission anniversary date; and (4-6-05)

02. Special Medicaid Rate. Participants who are receiving services that require a special Medicaid rate; and (4-6-05)

03. Selected Recertification. Participants identified during previous reviews whose improvement may remove the need for continuing NF care. (4-6-05)

522. -- 529. (RESERVED).

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

The Department will purchase service coordination services as described in IDAPA 16.03.17, "Service Coordination," for Medicaid eligible children age birth to twenty-one (21) years of age who meet medical necessity criteria. (4-6-05)

531. -- 534. (RESERVED).

535. 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)

536. EPSDT SERVICES.

EPSDT services include diagnosis and treatment involving medical care within the scope of MA, as well as dental services, eyeglasses, hearing aids, blood level testing, 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. (3-15-02)

01. Amount, Duration and Scope of Services. The Department will set amount, duration and scope for services provided under EPSDT. (4-5-00)

02. Services Must be Medically Necessary. 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 medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. (4-5-00)

03. Services Not Covered. The Department will not cover services for cosmetic, convenience or comfort reasons. (4-5-00)

04. Prior Authorization for Medical Necessity. 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. (4-5-00)

05. Additional Services. 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 Department or its designee will be required prior to payment. (4-5-00)

06. Services Which Are Least Costly. 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. (4-5-00)

537. WELL CHILD SCREENS.

01. Periodic Medical Screens. Periodic medical screens are to be completed at the following intervals: (3-15-02)

a. 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)

b. One (1) screen at or by age twelve (12) months, fifteen (15) months, eighteen (18) months, and twenty-four (24) months, including blood lead tests at age twelve (12) months and twenty-four (24) months. (3-15-02)

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

d. 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, including blood lead tests by age six (6) years, if the child has not been previously tested for blood lead levels. (3-15-02)

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

f. One (1) screen at initial program entry, up to the recipient's twenty-first birthday, including a blood lead level test, if not previously done. (3-15-02)

02. Interperiodic Medical Screens. (3-15-02)

a. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule in Subsection 537.01 and must be performed by a physician or physician extender. (3-15-02)

b. 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. Interperiodic screens 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. (3-15-02)

03. Developmental Screens. 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. (4-5-00)

04. EPSDT RN Screeners. 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. (4-5-00)

538. VISION SERVICES.

01. Vision Screens. 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 Section 537 of these rules, the vision screen is considered part of the medical screening service, (i.e. eye chart). (4-5-00)

02. Eye Exam Limitations. During any twelve (12) month period the Department will pay for one (1) eye examination for each eligible recipient by an ophthalmologist or optometrist during any twelve (12) month period to determine the need for glasses to correct or treat refractive error as outlined in Section 122. (4-5-00)

03. Eyeglass Limitations. Each eligible MA recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, is limited to one (1) pair of eyeglasses per year, except in the following circumstances: (4-5-00)

a. 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)

b. 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)

539. HEARING AIDS AND SERVICES.

The Department will provide hearing screening services according to the recommended guidelines of the AAP. (4-5-00)

01. Hearing Screens. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens, in accordance with Section 537, the hearing screen is considered part of the medical screening service. (4-5-00)

02. Hearing Services Paid Under EPSDT. 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. (4-5-00)

a. When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (7-1-99)

b. 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)

c. 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)

540. EPSDT REGISTERED NURSE SCREENER.

A licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions: (4-5-00)

01. Training Requirements. Can produce proof of completion of the Medicaid Child Health Assessment training course (or equivalent as approved by Medicaid) that: (4-5-00)

a. 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)

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

02. Linkage to Primary Care Services. 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 Medicaid Provider Agreement and Provider Number. (4-5-00)

03. Consultation. Has an established agreement with a physician or nurse practitioner for consultation on an as-needed basis. (4-5-00)

541. NUTRITIONAL SERVICES.

01. Nutritional Services. Nutritional services include intensive nutritional education, counseling, and monitoring by a registered dietitian 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. Nutrition services: (3-30-01)

a. Must be discovered by the screening services and ordered by the physician; and (3-30-01)

b. Must be medically necessary; and (3-30-01)

c. Must not be due to obesity; and (3-30-01)

d. If over two (2) visits per year are needed, must be authorized by the Department or its designee prior to the delivery of additional visits. (3-30-01)

02. Payment. Payment is made at a rate established in accordance with Subsection 106.06. (3-30-01)

542. DRUGS.

Drugs not covered by the Idaho Medicaid Program may be covered under the EPSDT program under the following conditions: (3-30-01)

01. Medically Necessary. Must be discovered as being medically necessary by the screening services; and (3-30-01)

02. Attending Physician. Must be ordered by the attending physician; and (3-30-01)

03. Authorized by Medicaid Program. Must be authorized by the Medicaid Program prior to the purchase of the drug. (3-30-01)

04. Experimental Drug. May not be an experimental drug in the treatment of the child's condition. (3-30-01)

543. OXYGEN AND RELATED EQUIPMENT.

Oxygen and related equipment are subject to Subsections 107.01.a., 107.01.b., 107.01.d., 107.04 and 107.05, except when discovered during screening services, are physician ordered and meet the following requirements: (3-30-01)

01. Oxygen Services. Oxygen services, PRN or as ordered on less than a continual basis, or when the lab requirements in Subsections 107.01.a., 107.01.b., 107.01.d., 107.04, and 107.05 are not met, 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: (3-30-01)

- a.** A diagnosis; (3-30-01)
- b.** Oxygen flow rate and concentration; and (3-30-01)
- c.** An estimate of the frequency and duration of use. (3-30-01)

02. Portable Oxygen Systems. Portable oxygen systems may be covered to complement a stationary system if the recipient is respirator dependent, or the physician documents the need for a portable oxygen system for use in transportation. (3-30-01)

03. Laboratory Evidence. Laboratory evidence of hypoxemia is not required. (3-30-01)

04. Authorized. Must be authorized prior to the delivery of service. (3-30-01)

544. DEFINITIONS FOR PRIVATE DUTY NURSING.

The following definitions apply to Sections 545 through Subsection 550.07 only. (4-5-00)

01. Primary RN. The RN identified by the family to be responsible for development, implementation, and maintenance of the Medical Plan of Care. (4-5-00)

02. Private Duty Nursing (PDN) RN Supervisor. An RN providing oversight of PDN services delegated to LPNs providing the child's care, in accordance with IDAPA 23.01.01, "Rules of the Board of Nursing". (4-5-00)

545. PRIVATE DUTY NURSING SERVICE.

Private Duty Nursing services are nursing services provided by a licensed professional nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. The nursing needs must be of such a nature that the Idaho Nursing 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 Home Health nursing services. PDN service must be authorized by the Department or its designee prior to delivery of service. (4-5-00)

01. Services. PDN Services must be ordered by a physician, and include: (4-5-00)

a. A function which can not be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing". (4-5-00)

b. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes: (4-5-00)

i. A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medications or other interventions; or (4-5-00)

ii. A licensed or professional nursing assessment to evaluate the child's responses to interventions or medications. (4-5-00)

02. Residences. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested 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: (4-5-00)

- a.** Licensed Nursing Facilities (NF); (4-5-00)
- b.** Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); (4-5-00)
- c.** Residential Care or Assisted Living Facilities; (4-5-00)
- d.** Licensed hospitals; and (4-5-00)
- e.** Public or private school. (4-5-00)

03. Plan of Care. Services delivered must be in a written plan of care, and the plan of care must: (4-5-00)

- a.** Be developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN, RN, or RN Supervisor, and a representative from the Department or its designee; (4-5-00)
- b.** Include all aspects of the medical, licensed, and personal care services medically necessary to be performed, including the amount, type, and frequency of such service; (4-5-00)
- c.** Must be approved and signed by the attending physician, parent or legal guardian, and primary PDN, RN, or RN supervisor, and a representative from the Department or its designee; and (4-5-00)
- d.** Must be revised and updated as child's needs change or upon significant change of condition, but at least annually, and must be submitted to the Department or its designee for review and prior authorization of service. (4-5-00)

04. Status Updates. Must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN supervisor completing the form. (4-5-00)

546. REDETERMINATION ANNUALLY. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: (4-5-00)

- 01. Review Eligibility.** Determine if the child continues to meet the PDN criteria in Section 545 of these rules. (4-5-00)
- 02. Review Services and Care Are Medically Necessary and Appropriate.** Assure that services and care are medically necessary and appropriate. (4-5-00)

547. FACTORS ASSESSED FOR REDETERMINATION. Factors assessed for redetermination include: (4-5-00)

- 01. Maintained in Personal Residence.** That the child is being maintained in their personal residence and receives safe and effective services through PDN services. (4-5-00)
- 02. Medical Justification.** The child receiving PDN services has medical justification and physician's orders. (4-5-00)
- 03. Written Plan of Care.** That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN, RN supervisor, and a representative from the Department or its

designee. (4-5-00)

04. Attending Physician. That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in his home. (4-5-00)

548. PRIMARY RN RESPONSIBILITY FOR PDN REDETERMINATION.

Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department or its designee at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department or its designee prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN services. The plan of care must include all requested material outlined in Subsection 545.03.a. through 545.03.d. of these rules. (4-5-00)

549. PHYSICIAN RESPONSIBILITIES.

Physician Responsibilities include: (4-5-00)

01. Medical Information. Provide the Department or its designee the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. (4-5-00)

02. Order Services. Order all services to be delivered by the private duty nurse. (4-5-00)

03. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. (4-5-00)

04. Community Resources. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department or its designee and facilitate the admission of the child to the appropriate medical facility. (4-5-00)

550. PRIVATE DUTY NURSE RESPONSIBILITIES.

RN supervisor or an RN providing PDN services responsibilities include: (4-5-00)

01. Notification of Physician. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery. (4-5-00)

02. Notification of Department or Its Designee. Notify the Department or its designee within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time. (4-5-00)

03. Evaluation of Condition. Evaluate changes of condition. (4-5-00)

04. Provide Services. Provide services in accordance with the nursing care plan. (4-5-00)

05. Records of Care. Private Duty Nurse ensures copies of records are to be maintained in the child's home. Records of care must include: (4-5-00)

a. The date; (4-5-00)

b. Time of start and end of service delivery each day; (4-5-00)

c. Comments on child's response to services delivered; (4-5-00)

d. Nursing assessment of child's status and any changes in that status per each working shift; (4-5-00)

e. Services provided during each working shift; and (4-5-00)

f. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a

representative from the Department. (4-5-00)

06. LPN Providers. In the case of LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and the Rules and IDAPA 23.01.01, "Rules of the Board of Nursing". (4-5-00)

a. RN Supervisor visits must occur at least once every thirty (30) days. (4-5-00)

07. Insure Health and Safety of Children. 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 child. (4-5-00)

551. -- 559. (RESERVED).

560. SCHOOL-BASED HEALTH-RELATED SERVICES PROVIDED BY IDAHO PUBLIC SCHOOL DISTRICTS AND THE IDAHO INFANT TODDLER PROGRAM UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA).

The Department will pay school districts, including charter schools and the Idaho Infant Toddler Program, for covered rehabilitative and health-related services under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program". Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code, that have entered into a provider agreement with the Department. Under the Individuals with Disabilities Act (IDEA), Part C, the Infant Toddler Program serves children from birth until their third birthday or until the beginning of the school year of their third birthday. Idaho public school districts provide services to students three (3) years of age through the semester of their twenty-first birthday. For children who are enrolled in the Infant Toddler Program, these rules apply only to services delivered by the Department or services delivered under a contractual agreement with the Idaho Infant Toddler Program, for which the Department will bill and reimburse the service provider. (3-20-04)

561. MEDICAID ELIGIBILITY.

To be eligible for medical assistance reimbursement for covered services, school districts and the Infant Toddler Program must ensure the student is: (3-20-04)

01. Medicaid Eligible. Eligible for Medicaid and the service for which the school district or Infant Toddler Program is seeking reimbursement; (3-20-04)

02. School Enrollment. Enrolled in an Idaho school district or the Idaho Infant Toddler Program; (3-20-04)

03. Age. Twenty-one (21) years of age or younger and the semester in which his twenty-first birthday falls is not finished; (3-20-04)

04. Educational Disability. (3-20-04)

a. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness"; or (3-20-04)

b. A child from birth to three (3) years of age, who has been identified as needing early intervention services due to a developmental delay or disability or who meets the eligibility criteria of the Idaho Infant Toddler Program; (3-20-04)

05. Individualized Education Program (IEP) and Other Service Plans. Covered by a current Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Services Plan (SP), developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically necessary health-related services and lists all the Medicaid reimbursable services for which the school district or agency is requesting reimbursement; and (3-20-04)

06. Referred by a Physician or Other Practitioner of the Healing Arts. Recommended or referred

by a physician or other practitioner of the healing arts such as a nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed and approved by the state of Idaho to make such recommendations or referrals, for all Medicaid services for which the school district or Infant Toddler Program is receiving reimbursement.

(3-20-04)

562. SERVICE-SPECIFIC ELIGIBILITY.

In addition to meeting the Medicaid eligibility requirements in Section 561 of these rules, Psychosocial Rehabilitation (PSR), Developmental Therapy, and Intensive Behavioral Intervention (IBI) have additional eligibility requirements.

(3-20-04)

01. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in Section 450 of these rules, or the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at: <http://www.sde.state.id.us/SpecialEd/manual/sped.asp>. Districts are to coordinate the delivery of services if the student is receiving PSR services authorized by the Department or its designee.

(3-20-04)

02. Developmental Therapy. To be eligible for developmental therapy, the student must meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the Developmental Disabilities Determination Checklist available online at: <http://www.sde.state.id.us/SpecialEd/medicaid>.

(3-20-04)

03. Intensive Behavioral Intervention (IBI). To be eligible for IBI services the student must:

(3-20-04)

a. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the Developmental Disabilities Determinations Checklist; and

(3-20-04)

b. Display self-injurious, aggressive or severely maladaptive behavior evidenced by a score of minus twenty-two (-22) or below on the Scales of Independent Behavior-Revised (SIB-R), and demonstrate functional abilities that are fifty percent (50%) or less of his chronological age in at least one (1) of the following: verbal or nonverbal communication, social interaction, or leisure and play skills.

(3-20-04)

563. EVALUATION AND DIAGNOSTIC SERVICES.

Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must:

(3-20-04)

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

(3-20-04)

02. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 569 of these rules;

(3-20-04)

03. Directed Toward Diagnosis. Be directed toward a diagnosis; and

(3-20-04)

04. Recommend Interventions. Include recommended interventions to address each need.

(3-20-04)

564. REIMBURSABLE SERVICES.

School districts and Infant Toddler programs may bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter school, or Infant Toddler Program is seeking reimbursement.

(3-20-04)

01. Annual IEP, IFSP, or SP (Plan) Development. A physician's referral is not required to bill for the

annual IEP, IFSP, or SP (plan) development. When the IEP team determines the student's need for health-related services, the meeting to develop the plan will be reimbursable. One (1) meeting per calendar year is reimbursable, even though the plan may be revised more frequently. School districts cannot bill separately for professionals attending the plan meeting. The plan must identify the type, frequency, duration, provider and location of each service for which it is seeking reimbursement. (3-20-04)

02. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursed. (3-20-04)

03. Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (3-20-04)

04. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school or Infant Toddler Program by the student. (3-20-04)

05. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (3-20-04)

06. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-20-04)

07. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN). (3-20-04)

08. Physical Therapy and Evaluation. (3-20-04)

09. Psychological Evaluation. (3-20-04)

10. Psychotherapy. (3-20-04)

11. Psychosocial Rehabilitation (PSR) and Evaluation. Psychosocial rehabilitation (PSR) and evaluation services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, study skills, and coping skills are reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. See Section 565 of these rules for a description of individual and group PSR services. (3-20-04)

12. Intensive Behavioral Intervention (IBI). Intensive behavioral interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. IBI is available only to children birth through the last day of the month of their twenty-first birthday who have self-injurious, aggressive or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, or leisure and play skills. (3-20-04)

a. Parent and Staff Consultation. Professionals may provide consultation to parents and to other staff who provide therapy for the child in other disciplines to assure successful integration and transition from IBI to other therapies and environments. (3-20-04)

b. Prior Authorization. Prior authorization for IBI services, when delivered by a school-based provider, will not be required beginning August 15, 2003. (3-20-04)

13. Speech/Audiological Therapy and Evaluation. (3-20-04)

14. Social History and Evaluation. (7-1-99)

15. Transportation Services. School districts and Infant Toddler programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (3-20-04)

a. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered by a physician; (3-20-04)

b. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-20-04)

c. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-20-04)

d. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-20-04)

e. The mileage, as well as the services performed by the attendant, are documented. See Section 576 of these rules for documentation requirements. (3-20-04)

16. Interpretive Services. Interpretive services needed by a student who does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (3-20-04)

a. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; (3-20-04)

b. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-20-04)

c. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-20-04)

565. PSYCHOSOCIAL REHABILITATION (PSR) SERVICES DESCRIPTION.

Psychosocial rehabilitation (PSR) services are to prevent the placement of a student in a more restrictive educational situation. The two (2) types of PSR are individual and group services. (3-20-04)

01. Individual PSR. Individual PSR includes one (1) or more of the following services: (3-20-04)

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the student learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management, and other skills related to the student's psychosocial circumstances; (3-20-04)

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors and to develop interventions with the student and employer or teacher. The progress report may be used to satisfy this requirement; (3-20-04)

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the student's emotional disturbance; (3-20-04)

d. Problem solving, support and supervision related to activities of daily living to assist the student to gain and utilize skills such as personal hygiene, household tasks, use of transportation, and money management; (3-20-04)

e. Development of coping skills and symptom management to identify the symptoms of emotional disturbance that are barriers to successful community integration and crisis prevention. (3-20-04)

02. Group PSR. Group PSR must be provided in accordance with the goals, objectives, and benchmarks specified on the plan. This is a service provided to two (2) or more students, at least one (1) of whom is a Medicaid participant. The purpose of the service is to aid students in work, school, or other activities related to their emotional disturbance in obtaining skills to live independently or in preventing movement to a more restrictive educational situation. Group PSR must include one (1) or more of the following: (3-20-04)

a. Employment or school-related groups to focus on symptom management on the job or in school, symptom reduction, and education about appropriate job- or school-related behaviors; (3-20-04)

b. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-20-04)

c. Symptom management groups to identify symptoms of emotional disturbance that are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members, and other support persons; and (3-20-04)

d. Activities of daily living groups which help students learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization and money management. (3-20-04)

566. -- 567. (RESERVED).

568. EXCLUDED SERVICES.

The following services are excluded from Medicaid payments to school based programs: (4-5-00)

01. Vocational Services. (4-5-00)

02. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. (4-5-00)

03. Recreational Services. (10-22-93)

569. PROVIDER STAFF QUALIFICATIONS.

Medicaid will only reimburse for services provided by qualified staff. See Section 574 of these rules for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (3-20-04)

01. IEP, IFSP, or SP Plan Development. The IEP, IFSP, or SP (plan) must be developed in accordance with the Idaho Special Education Manual or the Infant Toddler Program Implementation Manual. Plan development may only be billed when the plan includes reimbursable health-related services. (3-20-04)

02. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student. (3-20-04)

03. Developmental Therapy and Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Developmental Disabilities Agencies". Certified special

education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (3-20-04)

04. Medical Equipment and Supplies. See Section 564 of these rules. (3-20-04)

05. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (4-5-00)

06. Occupational Therapy and Evaluation. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (3-20-04)

07. Personal Care Services. Must be provided by or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing". (3-20-04)

08. Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (3-20-04)

09. Psychological Evaluation. Must be provided by a: (3-20-04)

a. Licensed psychiatrist; (3-20-04)

b. Licensed physician; (7-1-99)

c. Licensed psychologist; (5-3-03)

d. Psychologist extender registered with the Bureau of Occupational Licenses; or (3-20-04)

e. Certified school psychologist. (7-1-99)

10. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (3-20-04)

a. Psychiatrist, M.D.; (3-20-04)

b. Physician, M.D.; (3-20-04)

c. Licensed psychologist; (3-20-04)

d. Licensed clinical social worker; (3-20-04)

e. Licensed clinical professional counselor; (3-20-04)

f. Licensed marriage and family therapist; (3-20-04)

g. Certified psychiatric nurse (R.N.), as described in Section 456 of this chapter of rules; (3-20-04)

h. Licensed professional counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 569.10.a. through 569.10.g. of this rule; (3-20-04)

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (3-20-04)

- j. Psychologist extender registered with the Bureau of Occupational Licenses. (3-20-04)
- 11. **Psychosocial Rehabilitation.** Must be provided by a: (3-20-04)
 - a. Licensed physician or psychiatrist; (3-20-04)
 - b. Licensed master's level psychiatric nurse; (3-20-04)
 - c. Licensed psychologist; (7-1-99)
 - d. Licensed clinical professional counselor or professional counselor; (3-20-04)
 - e. Licensed marriage and family therapist; (3-20-04)
 - f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-20-04)
 - g. Psychologist extender registered with the Bureau of Occupational Licenses; (3-20-04)
 - h. Clinician; (3-20-04)
 - i. Licensed pastoral counselor; (3-20-04)
 - j. Licensed professional nurse (RN); (3-20-04)
 - k. Psychosocial rehabilitation specialist as defined in Section 456 of this chapter of rules; (3-20-04)
 - l. Licensed occupational therapist; (3-20-04)
 - m. Certified school psychologist; or (3-20-04)
 - n. Certified school social worker. (3-20-04)
- 12. **Intensive Behavioral Intervention.** Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Developmental Disabilities Agencies". (5-3-03)
- 13. **Speech/Audiological Therapy and Evaluation.** Must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. (3-20-04)
- 14. **Social History and Evaluation.** Must be provided by a licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (3-20-04)
- 15. **Transportation.** Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (3-20-04)

570. -- 573. (RESERVED).

574. PARAPROFESSIONALS.

Paraprofessionals, such as aides or therapy technicians, may be used by the school/Infant Toddler program to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician as defined by the scope of practice of the therapy professional. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. (4-5-00)

01. Student Evaluations. Paraprofessionals shall not conduct student evaluations or establish the IEP or IFSP goals. (4-5-00)

02. Competency of Paraprofessional. The professional must have assessed the competence of the paraprofessional or aide to perform assigned tasks. (4-5-00)

03. Monthly Orientation. The paraprofessional, on a monthly basis, shall be given orientation and training on the program and procedures to be followed. (4-5-00)

04. Reevaluation. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates. (4-5-00)

05. Changes in Condition. 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. (4-5-00)

06. Review of Independent Paraprofessional. 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. (4-5-00)

07. Utilizing Paraprofessional to Assist in Provision of Physical Therapy. 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: (4-5-00)

a. 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)

b. 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)

575. PAYMENT FOR SERVICES.

Payment for health-related services provided by school districts and Infant Toddler programs must be in accordance with rates established by the Department. (3-20-04)

01. Matching Funds. School districts and Infant Toddler programs are responsible for certification of the state portion of the Medicaid payment and must document, as part of their fiscal records, the non-federal funds that have been designated as their certified match. (3-20-04)

02. Payment in Full. Providers of services must accept as payment in full the Department's payment for such services and must not bill Medicaid participants for any portion of any charges. (3-20-04)

03. Third Party. For requirements regarding third party billing, see Section 030 of this chapter of rules. (3-20-04)

04. Contracted Providers. When a school program contracts with a service provider to deliver services identified on the plan, the school program must bill Medicaid for the contracted services. The contracted service provider must not bill Medicaid or the Medicaid participant. (3-20-04)

05. Inpatients in Hospitals or Nursing Homes. Payment for school-related or Infant Toddler-based services will not be provided to students who are inpatients in nursing homes or hospitals. Health-related services for students residing in an ICF/MR are eligible for reimbursement. (3-20-04)

06. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-20-04)

07. Access to Information. The provider will grant the Department immediate access to all information required to review compliance with these rules. (3-5-00)

576. RECORD REQUIREMENTS.

In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (3-20-04)

01. Service Detail Reports. A service detail report which includes: (4-5-00)

a. Name of student; (7-1-99)

b. Name and title of the person providing the service; (7-1-99)

c. Date, time, and duration of service; (3-20-04)

d. Place of service, if provided in a location other than school; and (3-20-04)

e. Student's response to the service. (3-20-04)

02. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (3-20-04)

03. Documentation of Qualifications of Providers. (4-5-00)

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (4-5-00)

05. Parental Notification. School districts and Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Section 577 of these rules. (3-20-04)

577. REQUIREMENTS FOR COOPERATION WITH AND NOTIFICATION OF PARENTS AND AGENCIES.

Each school district or Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (3-20-04)

01. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and Infant Toddler programs must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (3-20-04)

02. Notification to Primary Care Physician. School districts and Infant Toddler programs must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (3-20-04)

a. Results of evaluations within sixty (60) days of completion; (3-20-04)

b. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (3-20-04)

c. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (3-20-04)

03. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or

the current plan, the school district or Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (3-20-04)

04. Parental Consent to Release Information. School districts and Infant Toddler programs: (3-20-04)

a. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (3-20-04)

b. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services, including release of the name of the student's primary care physician. (3-20-04)

578. -- 599. (RESERVED).

600. 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 Access Unit Team comprised of the Access Unit Staff, and RMU Nurse Reviewer. 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. (7-1-99)

601. INFORMATION REQUIRED FOR DETERMINATION.

Required information includes a medical evaluation, an initial plan of care, social evaluation, psychological evaluation, and initial plan of care by ICF/MR. (7-1-99)

01. Medical Evaluation. 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: (7-1-99)

- a.** Diagnosis (primary and secondary); (7-1-99)
- b.** Medical findings and history; (7-1-99)
- c.** Mental and physical functional capacity; (7-1-99)
- d.** Prognosis; mobility status; and (7-1-99)
- e.** A statement by the physician certifying the level of care needed as ICF/MR for a specific recipient. (7-1-99)

02. Initial Plan of Care by Physicians. An initial plan of care, current within ninety (90) days of admission and signed and dated by the physician which includes: (7-1-99)

- a.** Orders for medications and treatments; (7-1-99)
- b.** Diet; and (7-1-99)
- c.** Professional rehabilitative and restorative services and special procedures, where appropriate. (7-1-99)

03. Social Evaluation. A social evaluation, current within ninety (90) days of admission, which includes: (7-1-99)

- a.** Condition at birth; (7-1-99)

- b.** Age at onset of condition; (7-1-99)
- c.** Summary of functional status, e.g. skills level, ADLs; and (7-1-99)
- d.** Family social information. (7-1-99)

04. Psychological Evaluation. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, which includes: (7-1-99)

- a.** Diagnosis; (7-1-99)
- b.** 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; (7-1-99)
- c.** Mental and physical functioning capacity; and (7-1-99)
- d.** Recommendation concerning placement and primary need for active treatment. (7-1-99)

05. Initial Plan of Care by ICF/MR. An initial plan of care developed by the admitting ICF/MR. (7-1-99)

602. -- 609. (RESERVED).

610. CRITERIA FOR DETERMINING ICF/MR LEVEL OF CARE.

To meet Title XIX entitlement for intermediate care for persons with mental retardation (ICF/MR level of care), and be eligible for services provided in an Intermediate Care Facility for the Mentally retarded (ICF/MR), or receive services under one of Idaho's programs to assist individuals with mental retardation or a related condition to avoid institutionalization in an ICF/MR. (7-1-99)

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of mental retardation or have a related condition defined in Section 66-402, Idaho Code; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (7-1-99)

02. Active Treatment. Persons living in an ICF/MR, must require and receive intensive inpatient active treatment as defined in Section 651, to advance or maintain his functional level. (7-1-99)

03. Must Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/MR, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization in the near future. (7-1-99)

04. Care for a Child. The department may provide Medicaid to a child (eighteen (18) years of age or younger), who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/MR, NF, or hospital. (7-1-99)

611. INDIVIDUALS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Individuals who have mental retardation or a related condition as defined in Section 66-402, Idaho Code, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/MR as indicated in Sections 612 through 615. (4-5-00)

612. CRITERION 1 -- FUNCTIONAL LIMITATIONS.

01. Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or (4-5-00)

02. Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or (4-5-00)

613. CRITERION 2 -- MALADAPTIVE BEHAVIOR.

01. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/MR level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior or SIB-R or subsequent revision is minus twenty-two (-22) or less; or (7-1-99)

02. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/MR level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or (4-5-00)

614. CRITERION 3 -- COMBINATION FUNCTIONAL/MALADAPTIVE BEHAVIORS.

Persons may qualify for ICF/MR level of care if they display a combination of Criterion 1 and 2 at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/MR, including active treatment services. Significance would be defined as: (7-1-99)

01. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB up to minus seventeen (-17), minus twenty-two (-22) inclusive; or (4-5-00)

02. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB between minus seventeen (-17), and minus twenty-two (-22) inclusive; or (4-5-00)

615. CRITERION 4 -- MEDICAL CONDITION.

Individuals may meet ICF/MR level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/MR, including active treatment services. (7-1-99)

616. -- 629. (RESERVED).

630. CHANGE IN ELIGIBILITY -- ICF/MR.

Individuals who were redetermined ineligible between November 1, 1998 and March 1, 1999 will be eligible to continue services until March 1, 2001. Individuals redetermined after March 1, 1999 will be eligible to continue services until March 1, 2001. Individuals who do not meet ICF/MR level of care after March 1, 2001, will lose Medicaid payment for services on the date specified by the RMU or Access unit. All new applicants after March 1, 1999 must meet this criteria to be eligible. (4-5-00)

01. Transitioning to a Less Restrictive Environment. Persons living in an ICF/MR shall be transitioned to a less restrictive environment within thirty (30) days of the determination that the recipient does not meet ICF/MR level of care. (4-5-00)

02. Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/MR eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (7-1-99)

03. Developmentally Disabled Waiver. Individuals receiving Developmentally Disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (7-1-99)

631. -- 649. (RESERVED).

650. DEFINITION OF MENTAL RETARDATION OR RELATED CONDITION.

Defined in Section 66-402, Idaho Code.

(7-1-99)

651. ACTIVE TREATMENT.

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: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status.

(7-1-99)

652. SERVICE AND ACTIVITIES NOT CONSIDERED ACTIVE TREATMENT.

Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; 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; interventions that address age-appropriate limitations; or general supervision of children who's age is such that such supervision is required by all children of the same age.

(7-1-99)

653. DETERMINATION OF NEED FOR ACTIVE TREATMENT.

The following criteria/components will be utilized when evaluating the need for active treatment:

(7-1-99)

01. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the recipient and the interventions needed; and

(7-1-99)

02. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed.

(7-1-99)

654. ANNUAL REDETERMINATION FOR ICF/MR LEVEL OF CARE.

The RMU or Access Unit staff must redetermine the participant's continuing need for ICF/MR level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation shall be accomplished no later than every three hundred sixty-five (365) days from the most recent determination.

(4-5-00)

655. ANNUAL RECERTIFICATION REQUIREMENT.

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.

(7-1-99)

656. -- 659. (RESERVED).

660. LEVEL OF CARE CHANGE.

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:

(7-1-99)

01. Discussed. Discussed with the facility administrator and/or the director of nursing services;

(7-1-99)

02. Physician Notified. The patient's/resident's physician is notified of the tentative decision; (7-1-99)

03. Submitted for Final Decision. The case is submitted to the Regional Review Committee for a final decision; and (7-1-99)

04. Effective Date of Loss of 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. (7-1-99)

661. APPEAL OF DETERMINATIONS.

The resident or his representative may appeal the decisions as set forth in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Section 000, et seq., and Section 301, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-99)

662. (RESERVED).

663. 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: (7-1-99)

01. Follow-Up Activities; (7-1-99)

02. A Verification of a Recipient's Appropriateness of Placement and/or Services; and (7-1-99)

03. Conduct Complaint Investigations at the Department's Request. (7-1-99)

664. WAIVER SERVICES FOR AGED OR DISABLED ADULTS.

The Department provides waiver services to eligible participants: 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 participant to be eligible, the Department must find that the participant: (4-5-00)

01. Has a Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (4-5-00)

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (4-5-00)

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility (NF) as set forth in Section 506. (3-30-01)

665. PURPOSE.

Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and/or community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. (4-5-00)

666. (RESERVED).

667. WAIVER PHASE IN.

The HCBS Waiver services will be provided statewide upon full implementation. New services will be phased in by geographic regions, beginning with Region VI beginning in March, 1999, followed by Regions V and VII in October, 1999, then Regions I and II in December, 1999, and Regions III and IV in February, 2000. (4-5-00)

668. TARGET GROUP.

Persons who would be medicaid eligible if residing in a NF, require the level of care provided in a NF, are over the age of eighteen (18), demonstrate significant disability on the Uniform Assessment Instrument (UAI), and have deficits which affect their ability to function independently. (4-5-00)

669. DEFINITIONS FOR WAIVER SERVICES FOR AGED OR DISABLED ADULTS.

The following definitions apply to Sections 664 through 704 of the rules: (4-6-05)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (3-5-00)

02. Personal Assistance Agency That Provides Fiscal Intermediary (FI) Services. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks are: (3-30-01)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-30-01)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-30-01)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-30-01)

d. To collect any participant participation due; (3-30-01)

e. To pay personal assistants and other waiver service providers for service; (3-30-01)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-30-01)

g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (3-30-01)

h. Make referrals for PCS eligible participant for service coordination when a need for such services is identified; and (4-6-05)

i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (3-30-01)

03. Fiscal Intermediary Services. Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (3-30-01)

04. Individual Service (IS) Plan. A document which outlines all services including, but not limited to, personal assistance services and IADLs, required to maintain the individual in his home and community. The plan is initially developed by the RMS or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMS and all Medicaid reimbursable services must be contained in the plan. (4-6-05)

05. Personal Assistance Agency or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (3-30-01)

06. Employer of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary. (3-30-01)

07. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (4-5-00)

08. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (4-5-00)

670. SERVICES PROVIDED.

01. Services Provided Under Waiver. Services that may be provided under the waiver are: (4-5-00)

- a.** Adult day care; (3-30-01)
- b.** Assistive technology; (4-5-00)
- c.** Assisted transportation; (4-5-00)
- d.** Attendant care; (4-5-00)
- e.** Service coordination; (4-6-05)
- f.** Chore services; (4-5-00)
- g.** Adult companion; (4-5-00)
- h.** Adult residential care; (4-5-00)
- i.** Consultation; (4-5-00)
- j.** Home delivered meals; (4-5-00)
- k.** Homemaker; (4-5-00)
- l.** Home modifications; (4-5-00)
- m.** Personal emergency response system; (4-5-00)
- n.** Psychiatric consultation; (4-5-00)
- o.** Respite care; and (4-5-00)
- p.** Skilled nursing. (4-5-00)

02. Administrative Case Management. The Department will also provide administrative case management. (4-5-00)

671. PRE-AUTHORIZATION REQUIREMENTS.

01. Pre-Authorization Requirements. All waiver services must be preauthorized by the Department. Authorization will be based on the information from: (3-30-01)

- a.** The UAI; (4-5-00)
- b.** The IS plan developed by the Department or its contractor; and (3-30-01)
- c.** Any other medical information which verifies the need for NF services in the absence of the waiver services. (4-5-00)

02. UAI Administration. The UAI will be administered, and the initial IS plan developed, by the RMU or its contractor. (3-30-01)

672. PROVIDER QUALIFICATIONS.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (4-5-00)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations where no agency exists, or no FI is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or FI is still not available. (3-30-01)

02. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks/activities in the Department's approved Aged and Disabled waiver as approved by the Health Care Financing Administration (HCFA). (3-30-01)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-30-01)

b. For the purposes of Section 672, a relative is defined as a spouse or parent of a minor child. (3-30-01)

03. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (4-5-00)

04. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (4-5-00)

05. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (4-5-00)

a. A master's degree in a behavioral science; (4-5-00)

b. Be licensed in accordance with state law and regulations; or (4-5-00)

c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-5-00)

06. Service Coordination. Service coordinators and service coordination agencies will meet the same requirements as PCS service coordinators specified in IDAPA 16.03.17, "Service Coordination," unless specifically modified by another section of these rules. (4-6-05)

07. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-30-01)

08. Adult Residential Care Providers. The facility will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. (4-5-00)

09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (4-5-00)

a. Supervising the direct service; (4-5-00)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

(4-5-00)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (4-5-00)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (4-5-00)

e. Being inspected and licensed as a food establishment by the district health department. (4-5-00)

10. Personal Emergency Response Systems. Providers must have a Land Mobile License from the Federal Communications Commission (FCC). (3-30-01)

673. ADULT DAY CARE.

Adult Day Care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (4-5-00)

01. Facilities. Facilities which provide adult day care must be maintained in safe and sanitary manner. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (4-5-00)

02. Providers' Homes. Providers accepting participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (4-5-00)

674. -- 675. (RESERVED).

676. ASSISTIVE TECHNOLOGY.

Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid state plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. All items shall meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (4-5-00)

677. ASSISTED TRANSPORTATION SERVICES.

Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (4-5-00)

01. Assisted Transportation Service. Assisted transportation service is offered in addition to medical transportation required in Section 150, and shall not replace it. (4-5-00)

02. Service Without Charge. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-5-00)

678. -- 679. (RESERVED).

680. ATTENDANT CARE.

Services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include, but are not limited to personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Additionally, it may include administration of medications, ventilator care, and tube feeding. Services may occur in the participant's home, community, work, school or recreational settings. (4-5-00)

01. Responsibility for Care. To utilize the services of a PAA acting as an FI, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-30-01)

02. Supervision. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (4-5-00)

681. PSYCHIATRIC CONSULTATION.

Direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (4-5-00)

682. CHORE SERVICES.

01. Intermittent Assistance. Intermittent assistance including, but not limited to: (4-5-00)

a. Yard maintenance; (4-5-00)

b. Minor home repair; (4-5-00)

c. Heavy housework; (4-5-00)

d. Sidewalk maintenance; and (4-5-00)

e. Trash removal to assist the participant to remain in their home. (4-5-00)

02. Chore Activities. Chore activities include: (4-5-00)

a. Washing windows; (4-5-00)

b. Moving heavy furniture; (4-5-00)

c. Shoveling snow to provide safe access inside and outside the home; (4-5-00)

d. Chopping wood when wood is the participant's primary source of heat; and (4-5-00)

e. Tacking down loose rugs and flooring. (4-5-00)

03. Availability of Services. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payor is willing to or is responsible for their provision. (4-5-00)

04. Rental Property. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-5-00)

683. ADULT COMPANION SERVICES.

01. Services. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. (4-5-00)

02. Service Activities. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to

provide companionship and be there in case they are needed. (4-5-00)

684. CONSULTATION.

01. Services to Participant or Family Member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. (3-30-01)

02. Services to the Provider. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (4-5-00)

685. HOMEMAKER SERVICES.

01. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (4-5-00)

02. Homemaker. The homemaker must be an employee of record or fact of an agency. (3-30-01)

686. -- 688. (RESERVED).

689. HOME DELIVERED MEALS.

01. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. (4-5-00)

02. Meals Delivered. Home delivered meals are limited to participants who: (4-5-00)

a. Rent or own their own home; (4-5-00)

b. Are alone for significant parts of the day; (4-5-00)

c. Have no regular caretaker for extended periods of time; and (4-5-00)

d. Are unable to prepare a balanced meal. (4-5-00)

690. HOME MODIFICATIONS.

01. Minor Housing Adaptations. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (4-5-00)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-5-00)

b. All services shall be provided in accordance with applicable state or local building codes. (4-5-00)

02. Permanent Environmental Modifications. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (4-5-00)

03. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (4-5-00)

04. Services Meet All Applicable Codes. All services must meet applicable state and/or local building, plumbing, electrical and/or requirements for certification. (4-5-00)

691. NURSING SERVICES.

01. Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. (4-5-00)

02. Nursing Services. Nursing services may include but are not limited to: (4-5-00)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (4-5-00)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (4-5-00)

c. Maintenance and monitoring of IV fluids and/or nutritional supplements which are to be administered on a continuous or daily basis; (4-5-00)

d. Injections; (4-5-00)

e. Blood glucose monitoring; and (4-5-00)

f. Blood pressure monitoring. (4-5-00)

692. SERVICE COORDINATION.

Service coordination includes all of the activities contained in IDAPA 16.03.17, "Service Coordination," Sections 250, 300 and 400. Such services are designed to foster independence of the participant, and will be time limited. (4-6-05)

01. Service Care. All services will be provided in accordance with an Individual Service Plan, which will take the place of the Individual Community Service Plan found in IDAPA 16.03.17, "Service Coordination," Section 400. All services will be incorporated into the Individual Service plan and authorized by the RMS. (4-6-05)

02. Requirements for an FI. Participants of PCS will have one (1) year from the date which services begin in their geographic region, as described in Section 667 of these rules, to obtain the services of an FI and become an employee in fact or to use the services of an agency unless the provisions of Subsection 670.01 are met. Provider qualifications are in accordance with Subsections 147.05 and 147.06. (3-30-01)

03. Notification by Service Coordinator. The service coordinator will notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (4-6-05)

693. PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

01. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. (4-5-00)

02. Limitations. PERS are limited to participants who: (4-5-00)

a. Rent or own their home, or live with unpaid relatives; (3-30-01)

- b.** Are alone for significant parts of the day; (4-5-00)
- c.** Have no caretaker for extended periods of time; and (3-30-01)
- d.** Would otherwise require extensive routine supervision. (4-5-00)

694. ADULT RESIDENTIAL CARE.

01. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that may include: (3-30-01)

- a.** Medication management; (4-5-00)
- b.** Assistance with activities of daily living; (4-5-00)
- c.** Meals, including special diets; (4-5-00)
- d.** Housekeeping; (4-5-00)
- e.** Laundry; (4-5-00)
- f.** Transportation; (4-5-00)
- g.** Opportunities for socialization; (4-5-00)
- h.** Recreation; and (4-5-00)
- i.** Assistance with personal finances. (4-5-00)

02. Administration Oversight. Administrative oversight must be provided for all services provided or available in this setting. (4-5-00)

03. Written Plan. A written IS plan will be negotiated between the participant or legal representative, and a facility representative. (3-30-01)

695. RESPITE CARE SERVICES.

01. Respite Care Services. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. (4-5-00)

02. Limitations. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (4-5-00)

696. PLACE OF SERVICE DELIVERY.

- 01. Place of Service Delivery.** Waiver services may be provided in the participant's: (4-5-00)
 - a.** Personal residence; (4-5-00)
 - b.** Employment program; or (4-5-00)
 - c.** Community. (4-5-00)
- 02. Excluded Living Situations.** Living situations specifically excluded as a personal residence are: (4-5-00)

- a. Skilled, or Intermediate Care Facilities; (4-5-00)
- b. Nursing Facility (NF); (4-5-00)
- c. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (4-5-00)
- d. Hospitals. (4-5-00)

697. ROLE OF THE REGIONAL MEDICAID UNIT.

The RMU will provide for the administration of the UAI, and the development of the initial IS plan. This will be done either by RMU staff or a contractor. The RMU will review and approve all IS plans, and the will authorize Medicaid payment by type, scope, and amount. (3-30-01)

01. Services Not in the IS Plan. Services which are not in the IS plan approved by the RMU are not eligible for Medicaid payment. (3-30-01)

02. Excess Services. Services in excess of those in the approved IS plan are not eligible for Medicaid payment. (3-30-01)

03. Early Approval Date. The earliest date that services may be approved by the RMU for Medicaid payment is the date that the participant's IS plan is signed by the participant or his designee. (3-30-01)

698. SERVICE DELIVERED FOLLOWING A WRITTEN INDIVIDUAL SERVICE PLAN.

All waiver services must be authorized by the RMU in the Region where the participant will be residing and provided based on a written IS plan. (3-30-01)

01. Development of the IS Plan. The initial IS plan is developed by the RMU or its contractor, based on the UAI, in conjunction with: (3-30-01)

- a. The waiver participant (efforts must be made to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); and (4-5-00)
- b. The guardian, when appropriate; and (4-5-00)
- c. The supervising nurse or case manager, when appropriate; and (4-5-00)
- d. Others identified by the waiver participant. (4-5-00)

02. Contents of the IS Plan. The IS plan must include the following: (3-30-01)

- a. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; and (4-5-00)
- b. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; and (4-5-00)
- c. The providers of waiver services when known; and (4-5-00)
- d. Documentation that the participant has been given a choice between waiver services and institutional placement; and (4-5-00)
- e. The signature of the participant or his legal representative, agreeing to the plan. (3-30-01)

03. IS Plan Revision. The plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-30-01)

04. Authorization of Services. All services reimbursed under the Home and Community Based Waiver must be authorized by the RMU prior to the payment of services. (4-5-00)

05. Service Supervision. The IS plan, which includes all waiver services, is monitored by the PAA, participant, family, and the RMU or its contractor. (3-30-01)

699. PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the RMU. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)". In addition, waiver participants must meet the following requirements. (3-30-01)

01. Requirements for Determining Participant Eligibility. The RMU must determine that: (4-5-00)

a. The participant would qualify for NF level of care as set forth in Section 506, if the waiver services listed in Section 664 of these rules were not made available; and (3-30-01)

b. The participant could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must be made by the RMU. Prior to any denial of services on this basis, the Department must verify that services to correct the concerns of the team are not available. (3-30-01)

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of NF care. (4-5-00)

d. Following the approval by the RMU for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (4-5-00)

02. Admission to a Nursing Facility. A participant who is determined by the RMU to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to an NF. (4-5-00)

03. Redetermination Process. Case Redetermination will be conducted by the RMU or its contractor. The redetermination process will verify that the participant continues to meet NF level of care and the participant's continued need for waiver services. (4-5-00)

700. PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are: (4-5-00)

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. (3-30-01)

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department's payment system contractor. (4-5-00)

03. Calculation of Fees. 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 participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (4-5-00)

701. PROVIDER RECORDS.

Records will be maintained on each waiver participant. (4-5-00)

01. Service Provider Information. Each service provider shall document each visit made or service provided to the participant, and will record at a minimum the following information: (4-5-00)

- a. Date and time of visit; and (4-5-00)
- b. Services provided during the visit; and (4-5-00)
- c. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (4-5-00)
- d. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMU or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-5-00)

02. Original Record. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMU. Failure to maintain documentation according to these rules shall result in the recoupment of funds paid for undocumented services. (4-5-00)

03. Individual Service Plan. The IS plan initiated by the RMU or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 698.02 and a copy of the most current IS plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current IS plan and UAI will be available from the RMU to each individual service provider with a release of information signed by the participant or legal representative. (3-30-01)

702. PROVIDER RESPONSIBILITY FOR NOTIFICATION.

The service provider is responsible to notify the RMU, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-30-01)

703. RECORDS RETENTION.

PAA's, and other providers are responsible to retain their records for five (5) years following the date of service. (3-30-01)

704. HOME AND COMMUNITY BASED SERVICES WAIVER PARTICIPANT LIMITATIONS.

The number of Medicaid participants to receive waiver services under the home and community based services waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants 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 participants will be October 1 of each new waiver year. (4-5-00)

705. -- 764. (RESERVED).

765. WAIVER SERVICES FOR ADULTS WITH A TRAUMATIC BRAIN INJURY.

Pursuant to 42 CFR Section 435.217, it is the intention of the Department to provide waiver services to eligible participants 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 participant to be eligible, the Department must find that the participant requires services due to a traumatic brain injury 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, require the level of care provided in a nursing facility as set forth in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 506. (3-20-04)

766. ELIGIBLE TARGET GROUP.

Persons who are Medicaid eligible, whose injury to the brain occurred on or after the age of twenty-two (22) and have been diagnosed with a traumatically acquired non-degenerative, structural brain injury resulting in residual deficits and disability who require the level of care provided in a nursing facility. (7-1-99)

767. DIAGNOSTIC CRITERIA.

In order to qualify for the waiver under this rule the person must have a diagnosis listed in the International Classification of Diseases - Clinical Modification Medicode (ICD-CM). The diagnosis must be within one (1) of the classification codes listed

TABLE 767	
Classification Code Number	Classification Description
348.1	Anoxic brain damage
431	Intra cerebral hemorrhage
800 - 800.9	Fracture of a vault of the skull
801 - 801.99	Fracture of the base of the skull
803 - 803.99	Other skull fractures
804 - 804.99	Multiple fractures involving the skull, face, and other bones
850 - 850.9	Concussion
851 - 851.9	Cerebral laceration and contusion
852 - 852.99	Subarachnoid, subdural, and extradural hemorrhage following injury
853 - 853.99	Other unspecified Intra cerebral hemorrhage following injury
854 - 854.99	Intracranial injury of other and unspecified nature
905 - 907.0	Late effects of skull and face fractures plus late effects of intracranial injury without fractures

(3-20-04)

768. SERVICES PROVIDED.

Services that may be provided under the waiver consist of residential habilitation, chore, respite care, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, personal emergency response system, day rehabilitation, home delivered meals, behavior consultation/crisis management, and skilled nursing services. Also included are extended state plan services including administrative case management, physical therapy, occupational therapy, speech therapy, personal care services. (7-1-99)

769. RESIDENTIAL HABILITATION.

Services consist of an integrated array of individually-tailored services and supports furnished to eligible participants 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 are listed in sections 769 through 771 of these rules. (3-20-04)

770. HABILITATION SERVICES.

Services consist of 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: (7-1-99)

01. Self-Direction. Self-direction consists of 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; (7-1-99)

02. Money Management. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-99)

03. Daily Living Skills. Daily living skills consists of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living

including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures;
(7-1-99)

04. Socialization. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature);
(3-20-04)

05. Mobility. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community;
(7-1-99)

06. Behavior Shaping and Management. Behavior shaping and management consists of 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.
(7-1-99)

771. PERSONAL ASSISTANCE SERVICES.

Services consist of assisting the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-20-04)

772. PERSONAL ASSISTANCE SERVICES SKILLS TRAINING.

Skills training consists of teaching waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs.
(3-20-04)

773. -- 779. (RESERVED).

780. CHORE SERVICES.

Services consist of heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party 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 participant.
(3-20-04)

781. RESPITE CARE SERVICES.

Services consist of those services provided, on a short term basis, in the home of either the waiver participant 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 participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers.
(3-20-04)

782. SUPPORTED EMPLOYMENT.

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; 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.
(7-1-99)

783. EXCLUSIONS FROM SUPPORTED EMPLOYMENT.

01. Supported Employment Services. 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. (3-20-04)

02. Federal Financial Participation (FFP). FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-20-04)

784. TRANSPORTATION SERVICES.

Services consist of services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 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. (3-20-04)

785. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

Adaptations consist of interior or exterior physical adaptations to the home, required by the waiver participant'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 participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services 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 participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-20-04)

786. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES.

Specialized medical equipment and supplies consist of devices, controls, or appliances, specified in the Plan of Care which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds 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 participant. All items shall meet applicable standards of manufacture, design and installation. (3-20-04)

787. PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

PERS may be provided to monitor waiver participant safety and provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-20-04)

788. HOME DELIVERED MEALS.

Home delivered meals consist of meals designed to promote adequate waiver participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day, and who have no regular caretaker for

extended periods of time. (3-20-04)

789. EXTENDED STATE PLAN SERVICES.

01. Extended State Plan Services. Extended State Plan services under the waiver consist of 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: (3-20-04)

a. Services provided in the waiver participant's residence, day rehabilitation site, or supported employment site; (3-20-04)

b. Consultation with other service providers and family members; (7-1-99)

c. Participation on the participant's Plan of Care team. (3-20-04)

790. SKILLED NURSING SERVICES.

Services consist of intermittent or continuous oversight and skilled care in a non-congregate setting, which is within the scope of the Nurse Practice Act and as such must be provided by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are appropriate if they are available and more cost effective than a Home Health visit. Nursing services may include but are not limited to the insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material, the maintenance of volume ventilators including associated tracheotomy care, tracheotomy and oral pharyngeal suctioning, maintenance and monitoring of IV fluids and/or nutritional supplements which are to be administered on a continuous or daily basis, injections, blood glucose monitoring, and blood pressure monitoring. (3-20-04)

791. PERSONAL CARE SERVICES.

Services consist of assistance due to a medical condition which impairs physical or mental function and which maintains a participant safely and effectively in his own home or residence. Services include but are not limited to bathing, care of the hair, assistance with clothing, basic skin care, bladder and bowel requirements, medication management, food nutrition and diet activities, active treatment training programs, and non-nasogastric gastrostomy tube feedings. (3-20-04)

792. BEHAVIOR CONSULTATION/CRISIS MANAGEMENT.

Behavior consultation/crisis management consist of services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-20-04)

793. DAY REHABILITATION.

Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the participant resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care. Day rehabilitation services shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (3-20-04)

794. PLACE OF SERVICE DELIVERY.

Waiver services for participants with a traumatic brain injury may be provided in the participant's personal residence, certified family home, waiver facilities, day rehabilitation/supported employment program or community. The following living situations are specifically excluded as a personal residence for the purpose of these rules: (3-20-04)

01. Excluded as a Personal Residence. (7-1-99)

a. Licensed Skilled, or Intermediate Care Facilities, Certified Nursing Facility (NF) or hospital; and

(7-1-99)

b. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-99)

c. Residential Care or Assisted Living Facility. (3-20-04)

02. Additional Service Limitations. Additional limitations to specific services are listed under that service definition. (3-20-04)

795. SERVICE DELIVERED FOLLOWING A WRITTEN PLAN.

All waiver services must be authorized by the Regional Medicaid Services in the region where the participant will be residing and provided based on a written Plan of Care. (3-20-04)

01. Development of the Plan of Care. The Plan of Care is developed by the Plan of Care team which includes: (3-20-04)

a. The Waiver Participant. Efforts must be made to maximize the participant's participation on the team by providing him with information and education regarding his rights; and (3-20-04)

b. The Department's administrative case manager; and (3-20-04)

c. The guardian when appropriate; and (7-1-99)

d. May include others identified by the waiver participant. (3-20-04)

02. Assessment Process Approved by the Department. The Plan of Care must be based on an assessment process approved by the Department. (3-20-04)

03. Included in the Plan of Care. The Plan of Care must include the following: (3-20-04)

a. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and (7-1-99)

b. Supports and service needs that are to be met by the participant's family, friends and other community services; and (3-20-04)

c. The providers of waiver services when known; and (7-1-99)

d. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-20-04)

e. The signature of the participant or his legal representative and the case manager. (3-20-04)

f. The plan must be revised and updated by the Plan of Care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-20-04)

04. Authorization of Services. All services reimbursed under the Home and Community Based Waiver for participants with a traumatic brain injury must be authorized prior to the payment of services by the Regional Medicaid Services. (3-20-04)

05. Service Supervision. The Plan of Care which includes all waiver services is monitored by the Department's case manager. (3-20-04)

796. 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 Regional Medicaid Services in each region. (3-20-04)

01. Residential Habilitation Service Providers. Providers of residential habilitation services must meet the following requirements: (3-20-04)

a. 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 a Plan of Care; 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 certified 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; and have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-20-04)

b. The provider agency will be responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 796.01.c. of this rule, who has demonstrated experience in writing skill training programs. Additional training requirements may also include: 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. (3-20-04)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a Program Coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (4-6-05)

d. When residential habilitation services are provided in the provider's home, the agency must meet the environmental sanitation standards; fire and life safety standards; and building, construction and physical home standards for certification as a certified family home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (3-20-04)

02. Chore Service Providers. Providers of chore services must meet the following minimum qualifications: (7-1-99)

a. Be skilled in the type of service to be provided; and (7-1-99)

b. Demonstrate the ability to provide services according to a Plan of Care. (3-20-04)

03. Respite Care Service Providers. Providers of respite care services must meet the following minimum qualifications: (7-1-99)

a. Meet the qualifications prescribed for the type of services to be rendered, for instance. Residential Habilitation providers must be an employee of an agency selected by the waiver participant and/or the family or guardian; and (7-1-99)

b. Have received caregiving instructions in the needs of the person who will be provided the service; and (7-1-99)

c. Demonstrate the ability to provide services according to a Plan of Care; and (3-20-04)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; and (7-1-99)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of

services; and (7-1-99)

f. Be free of communicable diseases; and (3-20-04)

g. Have successfully completed a traumatic brain injury training course approved by the Department. (3-20-04)

04. Supported Employment Service Providers. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. (3-20-04)

05. Transportation Service Providers Must: (7-1-99)

a. Possess a valid driver's license; and (7-1-99)

b. Possess valid vehicle insurance. (7-1-99)

06. Environmental Modifications Service Providers. Environmental Modifications services must: (7-1-99)

a. Be done under a permit, if required; and (7-1-99)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-99)

07. Specialized Medical Equipment and Supplies. Specialized Medical Equipment and Supplies purchased under this service must: (7-1-99)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-99)

b. 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. (7-1-99)

08. Personal Emergency Response Systems. 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. (7-1-99)

09. Home Delivered Meal Services. Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-99)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; and (7-1-99)

b. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (7-1-99)

c. 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 (7-1-99)

d. 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 (7-1-99)

e. Provide documentation of current driver's license for each driver; and (7-1-99)

- f. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-99)

10. Extended State Plan Service Providers. 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 and have taken a traumatic brain injury training course approved by the Department. (3-20-04)

11. Nursing Service Providers. Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing and have taken a traumatic brain injury training course approved by the Department. (3-20-04)

12. Behavior Consultation/Crisis Management Service Providers. Behavior Consultation/Crisis Management Providers must meet the following: (7-1-99)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or (3-20-04)

b. Be a licensed pharmacist; or (7-1-99)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-99)

d. Take a traumatic brain injury training course approved by the Department. (3-20-04)

e. Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. (3-20-04)

13. Day Rehabilitation Providers. Day Rehabilitation Providers must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. (3-20-04)

14. Personal Care Service Providers. Personal Care Service providers must meet the requirements outlined in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Subsections 146.06.a. through 146.06.c. - PCS Provider Qualifications. Providers must take a traumatic brain injury training course approved by the Department. (4-6-05)

797. PARTICIPANT ELIGIBILITY DETERMINATION.

The Regional Medicaid Services determines whether the participant meets the NH level of care required for waiver eligibility. The self reliance specialist determines whether the participant meets the other MA eligibility requirements as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," Section 787. In addition, waiver participants must meet the following requirements: (3-20-04)

01. Requirements for Determining Participant Eligibility. The Regional Medicaid Services must determine that: (3-20-04)

a. The participant would qualify for NF level of care as set forth in Section 506 of these rules if the waiver services listed in Section 765 of these rules were not made available; and (3-20-04)

b. The participant could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must: be made by the Department's Case Manager, with input from the Plan of Care team; and prior to any denial of services on this basis, be determined by the Department's Case manager that services to correct the concerns of the team are not available. (3-20-04)

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of NF care and other medical costs. Individual participants 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 NF 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. (3-20-04)

d. Following the approval by the Regional Medicaid Services for services under the waiver, the participants must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-20-04)

02. Admission to a Nursing Facility. A participant who is determined by the Regional Medicaid Services to be eligible for services under the Home and Community Based Services Waiver for adults with a traumatic brain injury may elect to not utilize waiver services but may choose admission to an NF. (3-20-04)

03. Self Reliance Specialist. The participant's self reliance specialist 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 a NF except that the self reliance specialist will forward potentially eligible applications immediately to the Regional Medicaid Services for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (3-20-04)

04. Redetermination Process. Case Redetermination. (7-1-99)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)". Medical redetermination will be made at least annually by the Regional Medicaid Services, or sooner at the request of the participant, the self reliance specialist, 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. (3-20-04)

b. The redetermination process will assess the following factors: (7-1-99)

i. The participant's continued need for waiver services; and (3-20-04)

ii. Discharge from the waiver services program. (7-1-99)

798. PROVIDER REIMBURSEMENT.
The following outlines the criteria used in reimbursing providers for waiver services. (7-1-99)

01. Fee for Services. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-99)

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-99)

03. Calculation of Fees. 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 participant's home or other service delivery location when the participant is not being provided transportation. (3-20-04)

799. PROVIDER RECORDS.
Three (3) types of record information will be maintained on all participants receiving waiver services: (3-20-04)

01. Service Provider Information. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (3-20-04)

a. Date and time of visit; and (7-1-99)

b. Services provided during the visit; and (7-1-99)

c. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-20-04)

d. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Case manager to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-20-04)

e. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Regional Medicaid Services. Failure to maintain documentation according to these rules shall result in the recoupment of funds paid for undocumented services. (3-20-04)

02. Plan of Care. The Plan of Care which is initiated by the Regional Medicaid Services and developed by the case manager and the Plan of Care team must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 143.03 of these rules and a copy of the most current Plan of Care will be maintained in the participant's home and will be available to all service providers and the Department. (3-20-04)

03. Verification of Services Provided. In addition to the Plan of Care, at least monthly the case manager will verify in writing that the services provided were consistent with the Plan of Care. Any changes in the plan will be documented and include the signature of the case manager and when possible, the participant. (3-20-04)

800. PROVIDER RESPONSIBILITY FOR NOTIFICATION.

It is the responsibility of the service provider to notify the case manager when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-20-04)

801. RECORDS MAINTENANCE.

In order to provide continuity of services, when a participant is transferred among service providers, or when a participant changes case managers, all of the foregoing participant records will be delivered to and held by the Regional Medicaid Services until a replacement service provider or case manager assumes the case. When a participant leaves the waiver services program, the records will be retained by the Regional Medicaid Services as part of the participant's closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. (3-20-04)

802. HOME AND COMMUNITY-BASED WAIVER PARTICIPANT LIMITATIONS.

The number of Medicaid participants to receive waiver services under the home and community based waiver for participants with a traumatic brain injury 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 participants will be October 1 of each new waiver year. (3-20-04)

803. -- 804. (RESERVED).

805. PRESCRIPTION DRUG COVERAGE.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded under Section 811 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, as defined under Section 54-1705(27), Idaho Code, and which are deemed medically necessary as defined in Subsection 003.40 of these rules. (1-1-06)T

02. Drug Coverage for Dual Eligibles. For Medicaid participants who are also eligible for Medicare ("dual eligibles"), the Department will pay for Medicaid-covered drugs that are not covered by Medicare, Part D. Dual eligibles will be subject to the same limits and processes used for any other Medicaid participants. (1-1-06)T

806. PAYMENT FOR COVERED DRUGS.

Payment will be made, as provided in Section 817, only to pharmacies registered with the Department as a provider for the specific location where the service was performed. An out of the state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy and be properly enrolled as a Medicaid provider. (3-30-01)

807. DISPENSING FEE.

Dispensing Fee is defined as the cost of filling a prescription including direct pharmacy overhead and shall be one (1) of two (2) types: (4-5-00)

01. Regular Dose Fee. For services pertaining to the usual practice of pharmacy, including but not limited to: (4-5-00)

- a.** Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (4-5-00)
- b.** Participation in drug selection; (4-5-00)
- c.** Drug administration; (4-5-00)
- d.** Drug regimen and research reviews; (4-5-00)
- e.** Proper storage of drugs; (4-5-00)
- f.** Maintenance of proper records; (4-5-00)
- g.** Prescriber interaction; and (4-5-00)
- h.** Patient counseling. (4-5-00)

02. Unit Dose Fee. Unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a twenty-four (24) hour supply in any client's drug tray at any given time. These drug trays, which contain a twenty-four (24) hour supply of medication, shall be delivered to the facility at a minimum of five (5) days per week. (4-5-00)

808. (RESERVED).

809. LIMITATIONS ON PAYMENT.

Medicaid payment for prescription drugs will be limited as follows: (3-20-04)

01. Days' Supply. Medicaid will not cover any days' supply of prescription drugs which exceeds the quantity or dosage allowed by these rules. (3-20-04)

02. Brand Name Drugs. Medicaid will not pay for a brand name product which is part of the FUL (federal upper limit) or SMAC (state maximum allowable cost) listing when the physician has not specified the brand name drug to be medically necessary. (3-20-04)

03. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (3-20-04)

04. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Subsection 812.03 in these rules. (3-20-04)

05. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for clients whose drug utilization exceeds the standard client profile or disease management guidelines determined by the Department. (3-20-04)

810. PRIOR AUTHORIZATION.

01. Items Requiring Prior Authorization. Pharmaceutical items requiring prior authorization include: (3-20-04)

a. Amphetamines and related CNS stimulants; (3-20-04)

b. Growth hormones; (3-20-04)

c. Retinoids; (3-20-04)

d. Brand name drugs when an acceptable generic form exists; (3-20-04)

e. Medication otherwise covered by the Department for which there is a therapeutically interchangeable alternate medication identified by the Department. Therapeutically interchangeable means a medication that is interchangeable with another medication within the same pharmacologic or therapeutic class and is at least as effective as the medication for which it is being interchanged. The Director may exempt a drug from the prior authorization requirement described in Subsection 810.01 based upon appropriate criteria, including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the P&T committee. The Department determines, and will make available to providers, which drugs are therapeutically interchangeable using a number of resources that may include: (4-6-05)

i. Peer-reviewed medical literature; (3-20-04)

ii. Randomized clinical trials; (3-20-04)

iii. Drug comparison studies; (3-20-04)

iv. Pharmacoeconomic studies; (3-20-04)

v. Outcomes research data; (3-20-04)

vi. Idaho practice guidelines; and (3-20-04)

vii. Consultation with practicing physicians, pharmacists, and the Idaho Medicaid Medical Director. (3-20-04)

f. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines. (3-20-04)

g. Lipase inhibitors. (3-20-04)

h. Medications prescribed outside of the Food and Drug Administration approved indications. (3-20-04)

i. Medications excluded in Section 811 of these Rules that the Department accepts for other medically approved indications. (3-20-04)

02. Request for Prior Authorization. The prior authorization procedure is initiated by the prescriber who must submit the request to the Department in the format prescribed by the Department. (3-20-04)

03. Notice of Decision. The Department will determine coverage based on this request, and will notify the client of a denial. (4-6-05)

04. Emergency Situation. The Department will provide for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 USC 1396r-

8(d)(5)(B). (3-20-04)

05. Response to Request. The Department will respond within twenty four (24) hours to a request for prior authorization of a covered outpatient prescription drug as required in 42 USC 1396r-8(d)(5)(A). (3-20-04)

811. EXCLUDED DRUG PRODUCTS.

The following categories and specific products are excluded from coverage by Medicaid: (4-6-05)

01. Non-Legend Medications. Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status unless: (4-6-05)

a. They are included in Subsection 812.02 of these rules; or (1-1-06)T

b. The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the P&T committee. Therapeutically interchangeable is defined in Subsection 810.01.e. of these rules. (1-1-06)T

02. Legend Drugs. Any legend drugs for which federal financial participation is not available. (4-5-00)

03. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Subsection 812.03 of these rules. (3-20-04)

04. Amphetamines and Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Subsection 812.03 of these rules. (3-20-04)

05. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (3-20-04)

06. Impotency Aids. Impotency aids, either as medication or prosthesis. (4-5-00)

07. Nicotine Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products. (4-5-00)

08. Medications Utilized for Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (4-5-00)

09. Vitamins. Vitamins, unless included in Subsection 812.01 of these rules. (1-1-06)T

10. Dual Eligibles. Drug classes covered under Medicare, Part D, for Medicaid participants who are also eligible for Medicare. (1-1-06)T

812. ADDITIONAL COVERED DRUG PRODUCTS.

Additional drug products will be allowed as follows: (4-5-00)

01. Therapeutic Vitamins. Therapeutic vitamins may include: (4-5-00)

a. Injectable vitamin B12 (cyanocobalamin and analogues); (4-5-00)

b. Vitamin K and analogues; (4-5-00)

c. Pediatric legend vitamin-fluoride preparations; (4-5-00)

d. Legend prenatal vitamins for pregnant or lactating women; (4-5-00)

- e. Legend folic acid; (4-5-00)
- f. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (4-5-00)
- g. Legend vitamin D and analogues. (4-5-00)
- 02. Prescriptions for Nonlegend Products.** Prescriptions for nonlegend products may include: (4-5-00)
 - a. Insulin; (4-5-00)
 - b. Disposable insulin syringes and needles; (4-5-00)
 - c. Oral iron salts; and (4-5-00)
 - d. Permethrin. (4-5-00)

813. LIMITATION OF QUANTITIES.

Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the client. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (3-20-04)

- 01. Doses of Medication.** Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (4-5-00)
 - a. Cardiac glycosides; (4-5-00)
 - b. Thyroid replacement hormones; (4-5-00)
 - c. Prenatal vitamins; (4-5-00)
 - d. Nitroglycerin products - oral or sublingual; (4-5-00)
 - e. Fluoride and vitamin/fluoride combination products; and (4-5-00)
 - f. Nonlegend oral iron salts. (4-5-00)
- 02. Oral Contraceptive Products.** Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (4-5-00)

814. PHARMACY AND THERAPEUTICS COMMITTEE (P&T COMMITTEE).

- 01. Membership.** The P&T Committee is appointed by the Director and is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. (3-20-04)
- 02. Function.** The P&T Committee has the following responsibilities for the prior authorization of drugs under Subsection 810.01.e. of these rules: (3-20-04)
 - a. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Program specific to the prior authorization of drugs with therapeutically interchangeable alternatives. (3-20-04)
 - b. To receive evidence-based clinical and pharmacoeconomic data and recommend to the Department the agents to be exempt from prior authorization in selected classes of drugs with therapeutically interchangeable

alternatives. The recommendation of items to be exempt from prior authorization will be based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, and secondarily on cost. (3-20-04)

c. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation. (3-20-04)

d. To review drug utilization outcome studies and intervention reports from the Drug Utilization Review Board as part of the process of reviewing and developing recommendations to the Department. (3-20-04)

03. Meetings. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. The P&T Committee may adjourn to executive session to consider the following: (3-20-04)

a. Relative cost information for prescription drugs that could be used by representatives of pharmaceutical manufacturers or other people to derive the proprietary information of other pharmaceutical manufacturers; or (3-20-04)

b. Participant-specific or provider-specific information. (3-20-04)

815. SUPPLEMENTAL REBATES.

01. Purpose. The purpose of supplemental rebates is to enable the Department to purchase prescription drugs provided to Medicaid beneficiaries in a cost effective manner, whether or not these drugs are subject to prior authorization by the Department. The supplemental rebate may be one factor considered in exempting a prescription drug from prior authorization, but is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs. (3-20-04)

02. Rebate Amount. The Department or its designee may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. (3-20-04)

816. DISPENSING PROCEDURES.

The following protocol shall be followed for proper prescription filling. (4-5-00)

01. Obtaining a Prescription Drug. To obtain a prescription drug, a MA recipient or authorized agent shall present the recipient's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. (4-5-00)

02. Prescription Drug Refills. Refills of prescription drugs must be authorized by the prescriber on the original or new prescription order on file and each refill shall be recorded on the prescription or logbook, or computer print-out, or on the recipient's medication profile. (4-5-00)

03. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: (4-5-00)

a. 21 CFR Section 1300 et seq.; (4-5-00)

b. Title 54, Chapter 17, and Title 37, Chapter 1, 27, and 32, Idaho Code; (4-5-00)

c. IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy"; (4-5-00)

d. IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Sections 805 through 825. (4-5-00)

04. Nonpayment of Prescriptions. Prescriptions not filled in accordance with the provisions of Subsection 816.03 will be subject to nonpayment or recoupment. (4-5-00)

05. Prescriptions on File. Prescriptions shall be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request. (4-5-00)

817. PAYMENT PROCEDURES.

The following protocol shall be followed for proper reimbursement. (4-5-00)

01. Filing Claims. Pharmacists shall file claims electronically with Department approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form shall include information described in the pharmacy guidelines issued by the Department. (4-5-00)

02. Claim Form Review. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (3-30-01)

03. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (4-5-00)

04. Reimbursement. Reimbursement to pharmacies shall be limited to the lowest of the following: (4-5-00)

a. Federal Upper Limit (FUL), as established by the Health Care Financing Administration (HCFA), of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (4-5-00)

b. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (4-5-00)

c. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug and a reasonable operating margin, plus the assigned dispensing fee; or (4-5-00)

d. The pharmacy's usual and customary charge to the general public as defined in Subsection 817.03. (4-5-00)

05. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient as an outpatient or a resident in a care facility except: (4-5-00)

a. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (4-5-00)

b. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (4-5-00)

c. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (4-5-00)

d. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (4-5-00)

06. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (4-5-00)

07. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, shall be returned to the dispensing pharmacy when the client no longer uses the medication as follows: (3-15-02)

a. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (3-15-02)

b. A licensed skilled nursing care facility must return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (4-6-05)

c. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (4-6-05)

d. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (3-15-02)

e. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (4-6-05)

818. COMPARATIVE COSTS TO BE CONSIDERED.

Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies. (4-5-00)

819. -- 899. (RESERVED).

900. DENTAL SERVICES.

01. Dental Services Provided. Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion and are purchased from a licensed dentist or denturist. A Medicaid dental consultant will review requests for prior authorization, with accompanying documentation, to determine approval or denial. (3-15-02)

02. Covered Dental Services. Dental services are covered by Medicaid as described in Subsections 900.02.a. through 900.02.c. of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association. (3-20-04)

a. Covered dental services for children (through the month of their twenty-first birthday) are covered in Sections 900 through 914 and Section 916 of these rules. (3-20-04)

b. Dental services for women on the Pregnant Women and Children (PWC) Program are listed in Section 912 of these rules. (3-20-04)

c. Covered dental services for Medicaid eligible adults (persons who are past the month of their twenty-first birthday) who are not eligible under PWC or Qualified Medicare Beneficiary (QMB) are listed in Section 915 of these rules. (3-20-04)

03. Customary Fees. Medicaid reimburses dentists for procedures on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-20-04)

04. Non-Covered Services. Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules. (3-20-04)

901. DENTAL DIAGNOSTIC PROCEDURES.

TABLE 901 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	Description
01. General Oral Evaluations.	
The following evaluations are not allowed in combination of the same day:	
D0120	Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.
D0150	Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.
D0160	Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.
D0170	Re-evaluation, limited, problem focused. Established client, not post-operative visit.
02. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three-year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0240	Intraoral occlusal film.
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six-month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve-month period.
03. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
04. Diagnostic.	

TABLE 901 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	Description
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(3-20-04)

902. DENTAL PREVENTIVE PROCEDURES.

Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 902 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	Description
01. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
02. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for clients under age twenty (21).
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
03. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for clients under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.
04. Space Management Therapy.	
Space maintainers are allowed to hold space for missing teeth for clients under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

(3-20-04)

903. DENTAL RESTORATIVE PROCEDURES.

All restorations must be documented in the client's record to include: procedure, surface, and tooth number (if applicable). This record must be maintained for a period of five (5) years. (3-15-02)

01. Posterior Restoration. (3-15-02)

a. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (3-15-02)

b. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (3-15-02)

c. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (3-15-02)

d. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (3-15-02)

02. Anterior Proximal Restoration. (3-15-02)

a. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (3-15-02)

b. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle. (3-15-02))

c. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (3-15-02)

d. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (3-15-02)

03. Amalgams and Resin Restoration. (3-15-02)

a. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (3-15-02)

b. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (3-15-02)

c. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (3-15-02)

04. Crowns. (3-15-02)

a. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (3-15-02)

b. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (3-15-02)

05. Restorations by Codes. (3-15-02)

TABLE 903.05 - RESTORATION BY CODES	
Dental Code	Description
a.	Amalgam Restorations.

TABLE 903.05 - RESTORATION BY CODES

Dental Code	Description
D2140	Amalgam - one (1) surface, primary or permanent. Tooth designation required.
D2150	Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.
b. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	Resin - one (1) surface, anterior. Tooth designation required.
D2331	Resin - two (2) surfaces, anterior. Tooth designation required.
D2332	Resin - three (3) surfaces, anterior. Tooth designation required.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.
D2390	Resin based composite crown, anterior, primary or permanent. Tooth designation required.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
c. Crowns.	
D2710	Crown resin indirect. Tooth designation required. Prior authorization required.
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
d. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.

TABLE 903.05 - RESTORATION BY CODES	
Dental Code	Description
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required..
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

(3-20-04)

904. ENDODONTICS.

Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 904 - ENDODONTICS	
Dental Code	Description
01. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
02. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
03. Root Canal Therapy.	
Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
04. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.

TABLE 904 - ENDODONTICS	
Dental Code	Description
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.
D3999	Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.

(3-20-04)

905. PERIODONTICS.

TABLE 905 - PERIODONTICS	
Dental Code	Description
01. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
02. Non-Surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
03. Other Periodontal Services.	

TABLE 905 - PERIODONTICS	
Dental Code	Description
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for clients who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the client's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(3-20-04)

906. PROSTHODONTICS.

01. Removable Prosthodontics.

(3-15-02)

a. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. (3-15-02)

b. If full dentures are inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. (3-15-02)

c. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to clients age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the client is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. (3-20-04)

02. Removable Prosthodontics by Codes.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	Description
a. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
b. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	Description
c. Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
d. Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
e. Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
f. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	Description
D5899	Unable to deliver full or partial denture. Prior authorization required. If the client does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(3-20-04)

907. MAXILLO-FACIAL PROSTHETICS.

TABLE 907 - MAXILLO-FACIAL PROSTHETICS	
Dental Code	Description
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5951	Feeding aid. Narrative required when prior authorizing. Requires prior authorization.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5982	Surgical stent. Narrative required when prior authorizing. Requires prior authorization.
D5988	Surgical splint. Narrative required when prior authorizing. Requires prior authorization.
D5999	Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.

(3-15-02)

908. FIXED PROSTHODONTICS.

TABLE 908 - FIXED PROSTHODONTICS	
Dental Code	Description
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.

(3-15-02)

909. ORAL SURGERY.

Extraction codes include services for local anesthesia and routine preoperative and postoperative care.

TABLE 909 - ORAL SURGERY	
Dental Code	Description
01. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
02. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
03. Other Surgical Procedures.	

TABLE 909 - ORAL SURGERY	
Dental Code	Description
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to clients under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to clients under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
04. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
05. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
06. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
07. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
08. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

(3-20-04)

910. ORTHODONTICS.

01. Orthodontics. Limited to clients age zero (0) to twenty-one (21) years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. Clients already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant.

(3-20-04)

TABLE 910 - ORTHODONTICS	
Dental Code	Description
02. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
03. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a client's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, panorex, and treatment plan are required when prior authorizing. Requires prior authorization.
D8080	Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorex, and treatment plan are required when prior authorizing. Requires prior authorization.
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
04. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates client can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
D8220	Fixed appliance therapy. Fixed indicates client cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
05. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8050, D8060, D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.

TABLE 910 - ORTHODONTICS	
Dental Code	Description
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

(3-20-04)

911. ADJUNCTIVE GENERAL SERVICES.

TABLE 911 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	Description
01. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
02. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.
03. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
04. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. To be used when client's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per client. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.

TABLE 911 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	Description
D9430	Office visit for observation (during regularly scheduled hours). No other services performed.
D9440	Office visit after regularly scheduled hours.
05. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the client is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the client's record identifying the specific behavior problem and the technique used to manage it. Allowed once per client per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
D9940	Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every twelve (12) months.
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

(3-20-04)

912. PREGNANT WOMEN AND CHILDREN (PWC) CODES.

The following are the only codes covered for women on the Pregnant Women and Children (PWC) program.

TABLE 912 - PREGNANT WOMEN AND CHILDREN (PWC) CODES	
Dental Code	Description
01. Clinical Oral Examinations.	
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem.
02. Radiographs.	
D0220	Intraoral - periapical - first film.
D0230	Intraoral - periapical - each additional film.
D0330	Panoramic film.
03. Restorative Services.	

TABLE 912 - PREGNANT WOMEN AND CHILDREN (PWC) CODES	
Dental Code	Description
D2940	Sedative filling. Tooth designation required.
04. Pulp Capping.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required.
05. Adjunctive Periodontal Services.	
D4341	Periodontal scaling, root planning, four (4) or more contiguous teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
06. Oral Surgery.	
Extractions - includes local anesthesia and routine postoperative care.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
07. Surgical.	
Extractions - includes local anesthesia and routine postoperative care.	
D7210	Surgical removal of an erupted tooth requiring elevation of the mucoperiosteal flap and removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Tooth designation required.
D7230	Removal of impacted tooth - partially bony. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Tooth designation required.
08. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
09. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedures.
10. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
11. Professional Visits.	
D9420	Hospital Call. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client.

TABLE 912 - PREGNANT WOMEN AND CHILDREN (PWC) CODES	
Dental Code	Description
D9440	Office visit - after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(3-20-04)

913. DENTURIST POLICY GUIDELINES.

01. Overview. Idaho Medicaid processes charges submitted by Idaho licensed denturists for services provided to eligible clients. Approved services are limited to those services allowed by Idaho code for Idaho licensed denturists. (3-15-02)

02. Client Eligibility. Clients eligible for the Pregnant Women and Children (PWC) program or who have only QMB eligibility are not eligible for denturist services. (3-20-04)

03. Prior Authorization. Prior authorization is not required for the denturist procedures except for dental code D5899 found in Section 914 of these rules. (3-20-04)

04. Payment. Denturists will be reimbursed for procedures on a fee-for-service basis. Usual and customary charges will be paid up to the Medicaid maximum allowance. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-20-04)

05. Service Limitations. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (3-15-02)

914. DENTURIST PROCEDURE CODES.

The following codes are valid denturist procedure codes:

TABLE 914 - DENTURIST PROCEDURE CODES	
Dental Code	Description
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.

TABLE 914 - DENTURIST PROCEDURE CODES	
Dental Code	Description
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the client does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(3-20-04)

915. DENTAL CODES FOR ADULT SERVICES.

The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	Description
01. Dental Diagnostic Procedures. The definitions for these codes are in Section 901 of these rules.	
a. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
b. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0270	Bitewing - single film.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D0272	Bitewings - two (2) films.
D0274	Bitewings - four (4) films.
D0277	Vertical bitewings - seven (7) to eight (8) films.
D0330	Panoramic film.
02. Dental Preventive Procedures. The definitions for these codes are in Section 902 of these rules.	
a. Dental Prophylaxis.	
D1110	Prophylaxis - adult.
b. Fluoride Treatments.	
D1204	Topical application of fluoride - prophylaxis not included - adult.
03. Dental Restorative Procedures. The definitions for these codes are in Section 903.05 of these rules.	
a. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent.
D2150	Amalgam - two (2) surfaces, primary or permanent.
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
b. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
c. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
04. Endodontics. The definitions for these codes are in Section 904 of these rules.	
D3220	Therapeutic pulpotomy.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D3221	Pulpal debridement, permanent teeth.
05. Periodontics. The definitions for these codes are in Section 905 of these rules.	
a. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
b. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.
06. Prosthodontics. The definitions for these codes are in Section 906 of these rules.	
a. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
b. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
c. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
d. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
e. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
f. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
07. Oral Surgery. The definitions for these codes are in Section 909 of these rules.	
a. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.
D7230	Removal of impacted tooth -- partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
c. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
d. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
e. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
f. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
08. Adjunctive General Services. The definitions for these codes are in Section 911 of these rules.	

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	Description
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.
c. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
d. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(3-20-04)

09. Clients Eligible for Other Programs. Clients who are eligible for the Pregnant Women and Children (PWC) program or have only Qualified Medicare Beneficiary (QMB) eligibility are not covered under this section of rule.

(3-20-04)

916. DENTAL PRIOR AUTHORIZATION.

All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization requires written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment. Client Medicaid eligibility must be verified by the provider before the authorized service is rendered.

(3-15-02)

917. -- 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 Case Proceedings 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 16.05.01, "Use 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 16.03.09, 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)

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