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**IDAPA 16
TITLE 03
CHAPTER 13**

16.03.13 - PRIOR AUTHORIZATION FOR BEHAVIORAL HEALTH SERVICES

000. LEGAL AUTHORITY.

The Idaho Department of Health and Welfare has the authority to promulgate rules governing prior authorization under Sections 56-202(b) and 56-203(g), Idaho Code. (3-20-04)

001. TITLE, POLICY AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.13, "Prior Authorization For Behavioral Health Services". (3-20-04)

02. Policy and Scope. The policy is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. The implementation process for prior authorization of behavioral health will begin for new persons with their initial plans and for persons with existing plans at their annual plan date. Implementation of these new authorization processes will take one (1) full year to complete, beginning with annual plans expiring in March of 2004 and ending with annual plans expiring in February 2005. Persons that have not transitioned into the new prior authorization process will use the process in effect as of September 30, 2003, until their annual plan expires and comes up for annual review using the new processes. The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults: (3-20-04)

a. DD/ISSH Waiver services as described at IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 143; and (3-20-04)

b. Developmental Disability Agency services as described at IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 120 and IDAPA 16.04.11, "Developmental Disabilities Agencies"; and (3-20-04)

c. Service Coordination for persons with developmental disabilities as described at IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 118. (3-20-04)

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for these rules. (3-20-04)

003. RECONSIDERATIONS, COMPLAINTS, AND ADMINISTRATIVE APPEALS.

01. Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within thirty (30) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request. (3-20-04)

02. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid, Bureau of Care Management. (3-20-04)

03. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (3-20-04)

004. INCORPORATION BY REFERENCE.

The Department has incorporated by reference the following document: (3-20-04)

01. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (3-20-04)

02. Availability of Incorporated Documents. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, P.O. Box 83720, Boise, Idaho 83720-0036. (3-20-04)

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-20-04)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-20-04)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-20-04)

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (3-20-04)

05. Internet Website. The Department's internet website is found at "www.healthandwelfare.idaho.gov". (3-20-04)

006. PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records". (3-20-04)

007. -- 009. (RESERVED).

010. DEFINITIONS (A THROUGH L).

For the purposes of these rules the following terms are used as defined below: (3-20-04)

01. Adult. A person who is eighteen (18) years of age or older or an ISSH Waiver participant. (3-20-04)

02. Assessment. A process that is described in Section 100 of these rules for program eligibility and in Section 200 of these rules for plan of service. (3-20-04)

03. Budget. The level of financial support that corresponds to a participant's assessed needs, level of support determined by the SIB-R, and the past three (3) years' expenditures, when available. Using this information, the budget is negotiated with the plan developer, the participant, and the assessor. (3-20-04)

04. Clinical Review. A process of professional review that validates the need for continued services. (3-20-04)

05. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-20-04)

06. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-20-04)

07. Customer. Any stakeholder with the exception of the participant. (3-20-04)

- 08. Department.** The Idaho Department of Health and Welfare. (3-20-04)
- 09. Developmental Disability.** A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years of age and: (3-20-04)
- a.** Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other conditions found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (3-20-04)
 - b.** Results in substantial functional limitations in three (3) or more of the following areas of major life activity: (3-20-04)
 - i.** Self-care; (3-20-04)
 - ii.** Receptive and expressive language; (3-20-04)
 - iii.** Learning; (3-20-04)
 - iv.** Mobility; (3-20-04)
 - v.** Self-direction; (3-20-04)
 - vi.** Capacity for independent living; or (3-20-04)
 - vii.** Economic self-sufficiency; and (3-20-04)
 - c.** Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated. (3-20-04)
- 10. Exception Review.** A clinical review of a plan that falls outside the established standards. (3-20-04)
- 11. Interdisciplinary Team.** For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-20-04)
- 12. Intermediate Care Facility for Persons with Mental Retardation (ICF/MR).** An intermediate care facility whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with mental retardation or persons with related conditions. (3-20-04)
- 13. Level of Support.** An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-20-04)
- 011. DEFINITIONS (M THROUGH Z).**
For the purposes of these rules the following terms are used as defined below: (3-20-04)
- 01. Medical Necessity.** A service is medically necessary if: (3-20-04)
 - a.** It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-20-04)
 - b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-20-04)
 - c.** Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must

be made available to the Department upon request. (3-20-04)

- 02. Participant.** A person who receives health care services and is eligible for Medicaid. (3-20-04)
- 03. Person-Centered Planning Process.** A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-20-04)
- 04. Person-Centered Planning Team.** The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-20-04)
- 05. Plan Developer.** A paid or nonpaid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-20-04)
- 06. Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis. (3-20-04)
- 07. Plan Monitor Summary.** A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 300.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns. (3-20-04)
- 08. Plan of Service.** An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-20-04)
- 09. Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-20-04)
- 10. Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-20-04)
- 11. Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-20-04)
- 12. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-20-04)
- 13. Right Price.** The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-20-04)
- 14. Right Outcomes.** Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-20-04)
- 15. Service Coordination.** Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-20-04)
- 16. Service Coordinator.** An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 118. This includes Targeted Service Coordinators. (3-20-04)

17. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-20-04)

18. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department or its designee to determine waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-20-04)

19. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-20-04)

012. -- 099. (RESERVED).

100. DETERMINATION OF PROGRAM ELIGIBILITY FOR ADULTS WITH A DEVELOPMENTAL DISABILITY.

The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department or its designee. Initial and annual assessments must be performed by the Department or its designee. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and for ICF/MR level of care for waiver services in accordance with IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Sections 610 through 615. (3-20-04)

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-20-04)

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-20-04)

a. The assessment process must be completed; and (3-20-04)

b. The assessor must provide the results of the assessment to the participant. (3-20-04)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on mental retardation and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than mental retardation. A SIB-R will be administered by the Department or its designee for use in this determination. (3-20-04)

04. ICF/MR Level of Care Determination for Waiver Services. The assessor will determine ICF/MR level of care for adults in accordance with IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Sections 610 through 615. (3-20-04)

101. -- 199. (RESERVED).

200. ASSESSMENT FOR PLAN OF SERVICE.

The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following: (3-20-04)

01. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD and ISSH waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-20-04)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-20-04)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-20-04)

02. Medical/Social and Developmental History. (3-20-04)

03. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. The level of support score established by the SIB-R, as described in Chapter Five (5) of the SIB-R Comprehensive Manual, must be used as one (1) of the factors to establish a negotiated budget. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-20-04)

04. Participant's Medical Conditions, Risk of Deterioration, Living Conditions, and Individual Goals. (3-20-04)

05. Behavioral or Psychiatric Needs That Require Special Consideration. (3-20-04)

201. -- 209. (RESERVED).

210. DEVELOPING A PARTICIPANT BUDGET.

01. Methodology for Developing Participant Budget. The participant budget is developed using the following methodology: (3-20-04)

a. Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services; (3-20-04)

b. Review all assessment information identified in Section 200 of these rules; (3-20-04)

c. Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 210.01.c.). There are six (6) levels of support, each corresponding to a support score range.

TABLE 210.01.c. - LEVEL OF SUPPORT	
Support Score Range	Level of Support
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

(3-20-04)

d. Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (3-20-04)

02. Negotiating an Appropriate Budget. The assessor, the participant, and the plan developer must use all the information from Subsections 210.01.a. through 210.01.d. of this rule to negotiate an appropriate budget that will support the participant's identified needs. (3-20-04)

211. -- 299. (RESERVED).

300. PLAN OF SERVICE.

In collaboration with the participant, the Department or its designee must assure that the participant has one (1) plan of service. This plan of service is based on the negotiated participant budget referred to in Section 210 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-20-04)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 118. (3-20-04)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within thirty (30) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-20-04)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-20-04)

- a. Durable Medical Equipment (DME); (3-20-04)
- b. Transportation; and (3-20-04)
- c. Physical, speech and occupational therapy provided outside of a Development Disabilities Agency (DDA). (3-20-04)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (3-20-04)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-20-04)

- a. Review the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-20-04)
- b. Contact service providers to identify barriers to service provision; (3-20-04)
- c. Discuss participant satisfaction regarding quality and quantity of services; and (3-20-04)
- d. Review provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (3-20-04)
- e. Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as

well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-20-04)

06. Provider Status Reviews. Service providers, with exceptions identified in Section 340 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-20-04)

- a. The status of supports and services to identify progress; (3-20-04)
- b. Maintenance; or (3-20-04)
- c. Delay or prevention of regression. (3-20-04)

07. Plan Monitor Summary. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review. (3-20-04)

301. -- 309. (RESERVED).

310. CONTENT OF THE PLAN OF SERVICE.

The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-20-04)

311. -- 319. (RESERVED).

320. NEGOTIATION FOR THE PLAN OF SERVICE.

The plan of service must be negotiated with the participant if the requested services fall outside the negotiated budget or do not reflect the assessed needs. When the plan of service cannot be negotiated by the assessor, the plan developer, and the participant, it will be referred by the assessor to the Department's care manager for additional evaluation. Services will not be paid for unless they are authorized on the plan of service. (3-20-04)

321. -- 329. (RESERVED).

330. INFORMED CONSENT.

Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-20-04)

331. -- 339. (RESERVED).

340. PROVIDER IMPLEMENTATION PLAN.

Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-20-04)

- 01. Exceptions.** An implementation plan is not required for waiver providers of: (3-20-04)
 - a. Specialized medical equipment; (3-20-04)
 - b. Home delivered meals; (3-20-04)
 - c. Environmental modifications; (3-20-04)

- d. Non-medical transportation; (3-20-04)
- e. Personal emergency response systems (PERS); (3-20-04)
- f. Respite care; and (3-20-04)
- g. Chore services. (3-20-04)

02. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-20-04)

03. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-20-04)

341. -- 349. (RESERVED).

350. ADDENDUM TO THE PLAN OF SERVICE.

A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department or its designee. (3-20-04)

351. -- 399. (RESERVED).

400. COMMUNITY CRISIS SUPPORTS.

Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-20-04)

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-20-04)

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-20-04)

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-20-04)

401. -- 499. (RESERVED).

500. ANNUAL REAUTHORIZATION OF SERVICES.

A participant's plan of service must be reauthorized annually. The Department or its designee must review and authorize the new plan of service prior to the expiration of the current plan. (3-20-04)

01. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department or its designee by the plan developer at least thirty (30) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-20-04)

- a. Notify the providers who appear on the plan of service of the annual review date. (3-20-04)

b. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 300.06 of these rules. (3-20-04)

c. Convene the person-centered planning team to develop a new plan of service. (3-20-04)

02. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 200 through 320 of these rules. (3-20-04)

03. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-20-04)

04. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Section 350 of these rules. (3-20-04)

05. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-20-04)

06. Annual Assessment Results. An annual assessment must be completed in accordance with Sections 100 and 200 of these rules. (3-20-04)

501. -- 599. (RESERVED).

600. QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. (3-20-04)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-20-04)

03. Exception Review. The Department will complete a clinical review of plans of service that exceed the budget authorized by the assessor or are inconsistent with the participant's assessed needs. The supporting documentation must demonstrate the medical necessity of services in the plan of service. (3-20-04)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (3-20-04)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-20-04)

601. -- 999. (RESERVED).

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