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**IDAPA 16
TITLE 03
CHAPTER 10**

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), Idaho Code. (3-19-07)

02. General Administrative Authority. Title XIX and Title XXI, of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-19-07)

03. Administration of the Medical Assistance Program. (3-19-07)

a. Section 56-203(g), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-19-07)

b. Section 56-203(i), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-19-07)

c. Sections 56-250 through 56-257, Idaho Code, establish minimum standards that enable these rules. (3-19-07)

04. Fiscal Administration. (3-19-07)

a. Fiscal administration of these rules is authorized by Title XIX and Title XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated by reference in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-19-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-19-07)

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. Dental services for the Medicaid Enhanced Plan are covered under Sections 080 through 085 of these rules. (9-1-07)T

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

a. Cost verification of actual costs for providing goods and services; (3-19-07)

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)

c. Effectiveness of the service to achieve desired results or benefits; and (3-19-07)

- d. Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-19-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection as described in Sections 005 and 006 of these rules. (3-19-07)

003. ADMINISTRATIVE APPEALS.

Administrative appeals are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

004. INCORPORATION BY REFERENCE.

The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>. (3-19-07)

02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition). Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at <http://www.adacatalog.org>. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (9-1-07)T

03. 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. (3-19-07)

04. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

05. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-19-07)

06. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2, is available on the CMS internet site at http://cms.hhs.gov/manuals/pub151/PUB_15_1.asp and http://cms.hhs.gov/manuals/pub152/PUB_15_2.asp. (3-19-07)

07. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-19-07)

08. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (3-19-07)

09. 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>. (3-19-07)

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-19-07)

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. (3-19-07)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-19-07)

04. Telephone. (208) 334-5500. (3-19-07)

05. Internet Website Address. The website address is: <http://www.healthandwelfare.idaho.gov>. (3-19-07)

06. Division of Medicaid. The Division of Medicaid is located at 3232 Elder Street, Boise Idaho, 83705; Phone: (208) 334-5747. (3-19-07)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUEST.

01. Confidentiality of Records. Information received by the Department is subject to the provisions of IDAPA 16.05.01, "Use and Disclosure of Department Records," for the following records. (3-19-07)

a. A provider's reimbursement records. (3-19-07)

b. An individual's records covered by these rules. (3-19-07)

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (3-19-07)

007. (RESERVED).

008. AUDIT, INVESTIGATION AND ENFORCEMENT.

In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." (3-19-07)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Section 009.04 of these rules whom are employed or whom they contract has complied with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." (3-19-07)

02. Availability to Work or Provide Service. (3-19-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant record. (3-19-07)

b. Those individuals licensed or certified by the Department are not available to provide services or

receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-19-07)

03. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

04. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Care Providers. The criminal history and background check requirements applicable to providers of adult day care as provided in Sections 329 and 705 of these rules. (1-1-07)T

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (1-1-07)T

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (1-1-07)T

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Sections 329 and 705 of these rules. (1-1-07)T

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (1-1-07)T

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (1-1-07)T

g. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (1-1-07)T

h. Day Rehabilitation Providers. The criminal history and background check requirements applicable to day rehabilitation providers as provided in Section 329 of these rules. (1-1-07)T

i. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies," Section 009. (3-19-07)

j. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (1-1-07)T

k. Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 714. (3-19-07)

l. Personal Assistance Agencies Acting as Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

m. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

n. Psychiatric Consultation Providers. The criminal history and background check requirements applicable to psychiatric consultation providers as provided in Section 329 of these rules. (1-1-07)T

o. Psychosocial Rehabilitation Agencies. The criminal history and background check requirements

applicable to psychosocial rehabilitation agency employees as provided in Subsection 130.02 of these rules. (3-19-07)

p. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (1-1-07)T

q. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329 and 705 of these rules. (1-1-07)T

r. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

s. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (1-1-07)T

010. DEFINITIONS A THROUGH D.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02 Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a qualified 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. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (7-1-07)T

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. **Auditor.** The individual or entity designated by the Department to conduct the audit of a provider's records. (3-19-07)
11. **Audit Reports.** (3-19-07)
- a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)
- b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)
- c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)
12. **Bad Debts.** Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)
13. **Bed-Weighted Median.** A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)
14. **Capitalize.** The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)
15. **Case Mix Adjustment Factor.** The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)
16. **Case Mix Index (CMI).** A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)
- a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)
- b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)
- c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)
17. **Certified Family Home.** A home certified by the Department to provide care to one (1) or two (2) adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)
18. **Chain Organization.** A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)
19. **Claim.** An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

- 20. Clinical Nurse Specialist.** A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)
- 21. Collateral Contact.** Contact 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. (3-19-07)
- 22. Common Ownership.** An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)
- 23. Compensation.** The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)
- 24. Control.** Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)
- 25. Cost Center.** A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)
- 26. Cost Component.** The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)
- 27. Cost Reimbursement System.** A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)
- 28. Cost Report.** A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)
- 29. Cost Statements.** An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)
- 30. Costs Related to Patient Care.** All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)
- 31. Costs Not Related to Patient Care.** Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)
- 32. Customary Charges.** Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

33. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for the Mentally Retarded (ICF/MR). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

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

35. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

36. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

37. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries; and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

38. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

39. 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 medical assistance participant. (3-19-07)

011. DEFINITIONS E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. 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; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. 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)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with mental retardation. (3-19-07)

a. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

b. "Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)" means an entity as defined in Subsection 011.29 in this rule. (3-19-07)

c. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

d. "Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

e. "Urban Hospital-Based Nursing Facilities" means hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (3-19-07)

08. Fiscal Intermediary Agency. An entity that provides 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, training, 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. (7-1-07)T

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will

or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

- 11. Funded Depreciation.** Amounts deposited or held which represent recognized depreciation. (3-19-07)
- 12. Generally Accepted Accounting Principles (GAAP).** A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)
- 13. Goodwill.** The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)
- 14. Healthy Connections.** The primary care case management model of managed care under Idaho Medicaid. (3-19-07)
- 15. Historical Cost.** The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)
- 16. ICF/MR Living Unit.** The physical structure that an ICF/MR uses to house patients. (3-19-07)
- 17. Improvements.** Improvements to assets which increase their utility or alter their use. (3-19-07)
- 18. Indirect Care Costs.** The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

 - a.** Activities; (3-19-07)
 - b.** Administrative and general care costs; (3-19-07)
 - c.** Central service and supplies; (3-19-07)
 - d.** Dietary (non-"raw food" costs); (3-19-07)
 - e.** Employee benefits associated with the indirect salaries; (3-19-07)
 - f.** Housekeeping; (3-19-07)
 - g.** Laundry and linen; (3-19-07)
 - h.** Medical records; (3-19-07)
 - i.** Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)
 - j.** Plant operations and maintenance (excluding utilities). (3-19-07)
- 19. Inflation Adjustment.** The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)
- 20. Inflation Factor.** For use in establishing nursing facility prospective rates, the inflation factor is the

Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index.

(3-19-07)

21. 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.

(3-19-07)

22. 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:

(3-19-07)

a. At least one (1) registered nurse; and

(3-19-07)

b. One (1) qualified mental retardation professional; and when required, one (1) of the following:

(3-19-07)

i. A consultant physician; or

(3-19-07)

ii. A consultant social worker; or

(3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants.

(3-19-07)

23. 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.

(3-19-07)

24. Interest. The cost incurred for the use of borrowed funds.

(3-19-07)

25. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs.

(3-19-07)

26. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs.

(3-19-07)

27. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made.

(3-19-07)

28. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap.

(3-19-07)

29. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare.

(3-19-07)

30. Intermediate Care Facility for Persons with Mental Retardation (ICF/MR). An entity licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities.

(3-19-07)

31. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable.

(3-19-07)

012. DEFINITIONS L THROUGH O.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (3-19-07)

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (3-19-07)

03. 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. (3-19-07)

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-19-07)

05. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (3-19-07)

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-19-07)

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (3-19-07)

08. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (3-19-07)

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (3-19-07)

a. A relatively fixed location in the building; (3-19-07)

b. Capable of being moved, as distinguished from building equipment; (3-19-07)

c. A unit cost of five thousand dollars (\$5000) or more; (3-19-07)

d. Sufficient size and identity to make control feasible by means of identification tags; and (3-19-07)

e. A minimum life of three (3) years. (3-19-07)

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

11. Medicaid. Idaho's Medical Assistance Program. (3-19-07)

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (3-19-07)

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (3-19-07)

14. **Medical Necessity (Medically Necessary).** A service is medically necessary if: (3-19-07)
- a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-19-07)
 - b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-19-07)
 - c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-19-07)
15. **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. (3-19-07)
16. **Medicare Savings Program.** The program formerly known as "Buy-In Coverage," where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. (3-19-07)
17. **Minimum Data Set (MDS).** A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (3-19-07)
18. **Minor Movable Equipment.** Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (3-19-07)
- a. No fixed location and subject to use by various departments of the provider's facility; (3-19-07)
 - b. Comparatively small in size and unit cost under five thousand dollars (\$5000); (3-19-07)
 - c. Subject to inventory control; (3-19-07)
 - d. Fairly large quantity in use; and (3-19-07)
 - e. A useful life of less than three (3) years. (3-19-07)
19. **Necessary.** The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (3-19-07)
20. **Negotiated Service Agreement (NSA).** The plan reached by the resident and his representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (3-19-07)
21. **Net Book Value.** The historical cost of an asset, less accumulated depreciation. (3-19-07)
22. **New Bed.** Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a nursing facility is licensed on or after July 1, 1999. (3-19-07)

23. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (3-19-07)

24. Nonambulatory. Unable to walk without assistance. (3-19-07)

25. Nonprofit Organization. An organization whose purpose is to render services without regard to gains. (3-19-07)

26. Normalized Per Diem Cost. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. (3-19-07)

27. Nurse Practitioner. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

28. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for participants. It must be an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participant must require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. (3-19-07)

29. Nursing Facility Inflation Rate. See the definition of Inflation Factor in Subsection 011.17 of these rules. (3-19-07)

30. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (3-19-07)

31. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-19-07)

013. DEFINITIONS P THROUGH Z.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. For a nursing facility or an ICF/MR, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (7-1-07)T

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (7-1-07)T

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree

and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. PRM. The Provider Reimbursement Manual. (3-19-07)

12. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

13. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/MRs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (3-19-07)

15. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

- 22. Reasonable Property Insurance.** Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)
- 23. Recreational Therapy (Services).** Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (3-19-07)
- 24. Regional Medicaid Services (RMS).** Regional offices of the Division of Medicaid. (3-19-07)
- 25. Regional Nurse Reviewer (RNR).** A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)
- 26. Registered Nurse - R.N.** Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)
- 27. Related Entity.** An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider (3-19-07)
- 28. Related to Provider.** The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)
- 29. Residential Care or Assisted Living Facility.** A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)
- 30. Resource Utilization Groups (RUG).** A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-1-07)T
- 31. Skilled Nursing Care.** The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)
- 32. Social Security Act.** 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)
- 33. State Plan.** The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)
- 34. Supervision.** Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)
- 35. Title XVIII.** Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)
- 36. Title XIX.** Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)
- 37. Title XXI.** Title XXI of the Social Security Act, known as the State Children's Health Insurance

Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

38. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

39. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

40. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

41. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

42. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

43. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

44. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

45. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

014. -- 019. (RESERVED).

GENERAL PARTICIPANT PROVISIONS

020. 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: (3-19-07)

a. The participant's eligibility for medical assistance is based on approval for and receipt of a waiver service; and (3-19-07)

b. The participant's income exceeds the eligibility requirement under the HCBS income limit contained in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. (3-19-07)

02. Waiver Cost-Sharing. Participation in the cost of HCBS waiver services is determined as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-19-07)

021. MEDICARE SAVINGS PROGRAM FOR PARTICIPANTS COVERED BY MEDICARE.

The Department has an agreement with the Centers for Medicare and Medicaid Services (CMS) to pay the premiums for Parts A and B of Title XVIII for each participant eligible for Medicare and medical assistance regardless of whether the participant receives a financial grant from the Department. (3-19-07)

01. AABD Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance and an AABD grant is the first month of eligibility for the AABD grant. (3-19-07)

02. SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance who also receives SSI, but not AABD, is the first month of eligibility for medical assistance. (3-19-07)

03. Neither AABD or SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance 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 medical assistance. This would mean the third month of medical assistance eligibility for the participant. (3-19-07)

04. Update of Records. After the effective date of the Medicare Savings Program it takes the Social Security Administration up to one (1) month to update its records to show the Department's payment of the Medicare Savings Program premium. (3-19-07)

05. Policies for Treatment of the Medicare Savings Program. The Department advises each participant who is paying Parts A and B Medicare premiums to discontinue payments beginning the month the Medicare Savings Program becomes effective. Policies for treatment of the Medicare Savings Program for determining eligibility for medical assistance or AABD, grant amount for AABD, or patient liability are in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Policies for treatment of the Medicare Savings Program for determining participation of an HCBS participant are found in Section 020 of these rules. (3-19-07)

022. PARTICIPANT'S REQUIREMENTS FOR ESTATE RECOVERY.

A participant's estate may be obligated to pay the Medicaid program back for the amount Medicaid paid out for medical assistance during the participant's life. The requirements for that estate recovery are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 900. (3-19-07)

023. -- 024. (RESERVED).

025. GENERAL SERVICE LIMITATIONS.

Service limitations stated in these rules include any services received by a participant under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-19-07)

026. SELECTIVE CONTRACTING.

The Department may contract with a limited number of providers of certain Medicaid products and services, including: dental services, eyeglasses, transportation, and some medical supplies. (3-19-07)

027. -- 029. (RESERVED).

GENERAL REIMBURSEMENT PROVISIONS

030. COST REPORTING.

The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. (3-19-07)

031. -- 035. (RESERVED).

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. 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. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

- a.** The provider's actual charge for service; or (3-19-07)
- 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 (3-19-07)
- c.** The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant 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. (3-19-07)

03. Payment 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. (3-19-07)

037. -- 038. (RESERVED).

039. ACCOUNTING TREATMENT.

Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. (3-19-07)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 296 of these rules. (3-19-07)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (3-19-07)

03. Other Actions. Generally, overpayment will result in two (2) circumstances: (3-19-07)

- a.** If the cost report is not filed, the sum of the following will be due: (3-19-07)
 - i.** All payments included in the period covered by the missing report(s). (3-19-07)
 - ii.** All subsequent payments. (3-19-07)
- b.** Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following: (3-19-07)
 - i.** Discontinuance of overpayments (on an interim basis). (3-19-07)
 - ii.** Recovery of overpayments. (3-19-07)

040. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.

The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Subsection 001.03 of these rules. (3-19-07)

01. Expenditure Documentation. Documentation of expenditures must include the amount, date,

purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (3-19-07)

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. (3-19-07)

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (3-19-07)

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. (3-19-07)

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. (3-19-07)

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. (3-19-07)

05. Retention of Records. Records required in Subsections 040.01 through 040.03 of these rules must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. (3-19-07)

041. -- 049. (RESERVED).

050. DRAFT AUDIT REPORT.

Following completion of the audit field work on a hospital, nursing facility, or an ICF/MR, and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. (3-19-07)

01. Review Period. The provider will have a period of sixty (60) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended when the provider: (3-19-07)

a. Requests an extension prior to the expiration of the original review period; and (3-19-07)

b. Clearly demonstrates the need for additional time to properly respond. (3-19-07)

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. (3-19-07)

051. FINAL AUDIT REPORT.

The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report (3-19-07)

052. -- 059. (RESERVED).

060. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX AND TITLE XXI PROGRAMS.

01. Application for Participation and Reimbursement. Prior to participation in the Medical Assistance Program, facilities must be licensed or certified by the Bureau of Facility Standards, Medicaid Division, Department of Health and Welfare. The Bureau's recommendations are forwarded to the Division of Medicaid for

approval for a signed provider agreement. The Department issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid will establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (3-19-07)

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (3-19-07)

061. -- 069. (RESERVED).

070. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (3-19-07)

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (3-19-07)

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (3-19-07)

03. Sales and Rental of Extended Care Facilities. The exception is not applicable to sales, lease or rentals of nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished. See PRM, Sections 1008 and 1012. (3-19-07)

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (3-19-07)

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. See PRM, Section 1005. (3-19-07)

COVERED SERVICES

(Sections 075 - 799)

075. ENHANCED PLAN BENEFITS - COVERED SERVICES.

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," with the exception of coverage for dental services. In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (9-1-07)T

01. Dental Services. Dental Services are provided as described under Sections 080 through 085 of these rules. (9-1-07)T

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (3-19-07)

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. **Therapies.** Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)
06. **Long Term Care Services.** The following services are provided under the Long Term Care Services. (3-30-07)
- a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)
 - b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)
 - c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)
07. **Hospice.** Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)
08. **Developmental Disabilities Services.** (3-19-07)
- a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)
 - b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (3-19-07)
 - c. ICF/MR as described in Sections 580 through 649 of these rules. (3-19-07)
 - d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)
09. **Service Coordination Services.** Service coordination as described in 720 through 779 of these rules. (3-19-07)
10. **Breast and Cervical Cancer Program.** Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)
- 076. - 079. (RESERVED).**
- 080. DENTAL SERVICES - DEFINITIONS.**
Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion. These services must be purchased from a licensed dentist or denturist. (9-1-07)T
- 081. DENTAL SERVICES - PARTICIPANT ELIGIBILITY.**
01. **Children's Coverage.** Dental services for children, covered through the month of their twenty-first birthday, are listed in Sections 080 through 085 of these rules. (9-1-07)T
02. **Adult Coverage.** Covered dental services for Medicaid-eligible persons who are past the month of their twenty-first birthday who are not eligible under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Pregnant Women (PW), Qualified Medicare Beneficiary (QMB), or under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," are listed in Subsections 082.14 and 082.15 of these rules. (9-1-07)T
03. **Limitations on Orthodontics.** Orthodontics are limited to participants from birth to twenty-one (21) years of age who meet the eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. The Malocclusion Index may be found in Appendix A of these rules. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant. (9-1-07)T
04. **Participants Eligible for Other Programs.** Participants who have only Qualified Medicare

Beneficiary (QMB) eligibility are not eligible for dental services.

(9-1-07)T

082. DENTAL SERVICES - COVERAGE AND LIMITATIONS.

01. Covered Dental Services. Dental services are covered by Medicaid as described in Section 081 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association. (9-1-07)T

02. Non-Covered Services. Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in these rules. (9-1-07)T

03. Diagnostic Dental Procedures.

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	Description
a. General Oral Evaluations.	
The following evaluations are not allowed in combination of the same day:	
D0120	Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.
D0150	Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.
D0160	Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.
D0170	Re-evaluation, limited, problem focused. Established participant, not post-operative visit.
b. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three (3) year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0240	Intraoral occlusal film.
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. Seven (7) to eight (8) films. Allowed every six (6) months.

TABLE 082.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	Description
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six (36) month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four (4) bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve (12) month period.
c. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.
D0470	Diagnostic casts.
d. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(9-1-07)T

04. Dental Preventive Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	Description
a. Dental Prophylaxis.	
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
b. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants under age twenty (21).
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
c. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.

TABLE 082.04 - DENTAL PREVENTIVE PROCEDURES

Dental Code	Description
d. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for participants under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

(9-1-07)T

05. Restorations.

(9-1-07)T

a. Posterior Restoration.

(9-1-07)T

i. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (9-1-07)T

ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (9-1-07)T

iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (9-1-07)T

iv. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (9-1-07)T

b. Anterior Proximal Restoration.

(9-1-07)T

i. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (9-1-07)T

ii. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle. (9-1-07)T

iii. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (9-1-07)T

iv. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (9-1-07)T

- c. Amalgams and Resin Restoration. (9-1-07)T
 - i. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (9-1-07)T
 - ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (9-1-07)T
 - iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (9-1-07)T
- d. Crowns. (9-1-07)T
 - i. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (9-1-07)T
 - ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (9-1-07)T

TABLE 082.05 - RESTORATIONS	
Dental Code	Description
e. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent. Tooth designation required.
D2150	Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.
f. Resin Restorations.	
Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	Resin - one (1) surface, anterior. Tooth designation required.
D2331	Resin - two (2) surfaces, anterior. Tooth designation required.
D2332	Resin - three (3) surfaces, anterior. Tooth designation required.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.
D2390	Resin based composite crown, anterior, primary or permanent. Tooth designation required.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
g. Crowns.	
D2710	Crown resin indirect. Tooth designation required. Prior authorization required.

TABLE 082.05 - RESTORATIONS	
Dental Code	Description
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
h. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
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.

(9-1-07)T

06. Endodontics. Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 082.06 - ENDODONTICS	
Dental Code	Description
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	

TABLE 082.06 - ENDODONTICS	
Dental Code	Description
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
c. Root Canal Therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
d. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
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.

(9-1-07)T

07. Periodontics.

TABLE 082.07 - PERIODONTICS	
Dental Code	Description
a. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
b. Non-Surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
c. Other Periodontal Services.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the participant's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

08. Prosthodontics.

(9-1-07)T

a. Removable Prosthodontics.

(9-1-07)T

i. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. (9-1-07)T

ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. (9-1-07)T

iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month

when the participant is not eligible but other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. (9-1-07)T

b. Removable Prosthodontics by Codes.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	Description
i. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
iii. Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
v. Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.

TABLE 082.08.b. - PROSTHODONTICS	
Dental Code	Description
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
vii. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(9-1-07)T

09. Maxillo-Facial Prosthetics.

TABLE 082.09 - MAXILLO-FACIAL PROSTHETICS	
Dental Code	Description
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.

TABLE 082.09 - MAXILLO-FACIAL PROSTHETICS	
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.

(9-1-07)T

10. Fixed Prosthodontics.

TABLE 082.10 - FIXED PROSTHODONTICS	
Dental Code	Description
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

11. Oral Surgery.

TABLE 082.11 - ORAL SURGERY	
Dental Code	Description
a. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
c. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
d. Alveoloplasty.	

TABLE 082.11 - ORAL SURGERY	
Dental Code	Description
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
e. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
f. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

12. Orthodontics.

TABLE 082.12 - ORTHODONTICS	
Dental Code	Description
a. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.

TABLE 082.12 - ORTHODONTICS	
Dental Code	Description
b. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, 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.
c. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
D8220	Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
d. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8070, D8080 or D8090 a maximum of twenty-four (24) adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

(9-1-07)T

13. Adjunctive General Services.

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	Description
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.
c. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
d. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.
D9430	Office visit for observation (during regularly scheduled hours). No other services performed.
D9440	Office visit after regularly scheduled hours.
e. Miscellaneous Service.	

TABLE 082.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	Description
D9920	Behavior Management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
D9940	Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every twelve (12) months.
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

(9-1-07)T

14. Dental Codes For Adult Services. The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	Description
a. Dental Diagnostic Procedures. The definitions for these codes are in Subsection 082.03 of these rules.	
i. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
ii. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0270	Bitewing - single film.
D0272	Bitewings - two (2) films.
D0274	Bitewings - four (4) films.
D0277	Vertical bitewings - seven (7) to eight (8) films.
D0330	Panoramic film.
b. Dental Preventive Procedures. The definitions for these codes are in Subsection 082.04 of these rules.	
i. Dental Prophylaxis.	
D1110	Prophylaxis - adult.
ii. Fluoride Treatments.	
D1204	Topical application of fluoride - prophylaxis not included - adult.
c. Dental Restorative Procedures. The definitions for these codes are in Subsection 082.05 of these rules.	
i. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent.
D2150	Amalgam - two (2) surfaces, primary or permanent.
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
ii. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
iii. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
d. Endodontics. The definitions for these codes are in Subsection 082.06 of these rules.	
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
e. Periodontics. The definitions for these codes are in Subsection 082.07 of these rules.	
i. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
ii. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.
f. Prosthodontics. The definitions for these codes are in Subsection 082.08.b. of these rules.	
i. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
iii. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.

TABLE 082.14 - DENTAL CODES FOR ADULTS

Dental Code	Description
v. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
vi. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Oral Surgery. The definitions for these codes are in Subsection 082.11 of these rules.	
i. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
ii. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.
D7230	Removal of impacted tooth -- partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
iii. Other Surgical Procedures.	

TABLE 082.14 - DENTAL CODES FOR ADULTS	
Dental Code	Description
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
iv. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. Adjunctive General Services. The definitions for these codes are in Subsection 082.13 of these rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(9-1-07)T

15. Denturist Procedure Codes.

(9-1-07)T

- a.** The following codes are valid denturist procedure codes:

TABLE 082.15.a. - DENTURIST PROCEDURE CODES	
Dental Code	Description
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

(9-1-07)T

b. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial

denture construction service for the first six (6) months. (9-1-07)T

083. DENTAL SERVICES - PROCEDURAL REQUIREMENTS.

01. Dental Prior Authorization. All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization requires a written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment. (9-1-07)T

02. Denturist Prior Authorization. Prior authorization is not required for dentist procedures except for dental code D5899 found in Subsection 082.15.a. of these rules. (9-1-07)T

03. Crowns. (9-1-07)T

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. (9-1-07)T

b. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (9-1-07)T

084. DENTAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

All dental services must be documented in the participant's record to include: procedure, surface, and tooth number, if applicable. This record must be maintained for a period of six (6) years. (9-1-07)T

085. DENTAL SERVICES - PROVIDER REIMBURSEMENT.

Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and customary charges are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (9-1-07)T

086. -- 089. (RESERVED).

SUB AREA: ENHANCED HOSPITAL SERVICES

(Sections 090 Through 099)

090. 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. (3-19-07)

091. - 092. (RESERVED).

093. ORGAN TRANSPLANTS - COVERAGE AND LIMITATIONS.

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. (3-19-07)

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. (3-19-07)

03. Intestinal Transplants. Intestinal transplant surgery will be covered only for patients with irreversible intestinal failure, and who have failed total parenteral nutrition. (3-19-07)

04. Coverage Limitations. (3-19-07)

a. Multi-organ transplants may be covered when: (3-19-07)

i. The primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process; and (3-19-07)

ii. The damage to the second organ will compromise the outcome of the transplant of the primary organ. (3-19-07)

b. Each kidney or lung is considered a single organ for transplant; (3-19-07)

c. Re-transplants will be covered only if the original transplant was performed for a covered condition and if the re-transplant is performed in a Medicare/Medicaid approved facility; (3-19-07)

d. A liver transplant from a live donor will not be covered by the Medical Assistance Program; (3-19-07)

e. No organ transplants covered by the Medical Assistance Program unless prior authorized by the Department, and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. (3-19-07)

05. Follow-Up Care. Follow-up care to a participant who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation. (3-19-07)

094. -- 095. (RESERVED).

096. ORGAN TRANSPLANTS - PROVIDER REIMBURSEMENT.

Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of ninety-six and a half percent (96.5%) of reasonable costs under Medicare payment principles or customary charges. Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered. (3-19-07)

097. -- 099. (RESERVED).

SUB AREA: ENHANCED MENTAL HEALTH SERVICES

(Sections 100 Through 199)

100. INPATIENT PSYCHIATRIC HOSPITAL SERVICES.

In addition to psychiatric services covered under inpatient hospital services and inpatient psychiatric hospital services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits," the Medicaid Enhanced Plan Benefit include enhanced medically necessary services for certain individuals under the age of twenty-one (21) in free standing psychiatric hospitals (Institutions For Mental Disease). (3-19-07)

101. (RESERVED).

102. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - ELIGIBILITY.

All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 707 apply to Inpatient Psychiatric Hospital services in this chapter of rules. (3-19-07)

01. Limitation Exemption. The ten (10) day limitation does not apply to participants who are eligible for inpatient psychiatric hospital services under this chapter of rule. (3-19-07)

02. Individuals Over 65. Individuals over age sixty-five (65) are eligible for inpatient psychiatric hospital services under this chapter of rule. (3-19-07)

103. - 109. (RESERVED).

110. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES.

In addition to mental health services covered under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 710 through 717, the Medicaid Enhanced Plan Benefits includes the following enhanced outpatient mental health benefits. (3-19-07)

01. Psychotherapy. The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 115.01 of these rules. (3-19-07)

02. Partial Care Services. The enhanced services include partial care services in a Mental Health Clinic as described in Subsection 115.02 of these rules. (3-19-07)

03. Psychosocial Rehabilitation. The enhanced services include psychosocial rehabilitation as described in Sections 123 through 146 of these rules. (3-19-07)

111. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - DEFINITIONS.

These definitions apply to Sections 100 through 146 of these rules. (3-19-07)

01. Assessment Hours. Time allotted for completion of evaluation and diagnostic services. (3-19-07)

02. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (3-19-07)

03. Goal. The desired outcome related to an identified issue. (3-19-07)

04. Initial Contact. The date a participant, parent, or legal guardian requests Enhanced Plan services. (3-19-07)

05. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)

06. 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. (3-19-07)

07. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)

08. Partial Care. Partial care is treatment for those children with serious emotional disturbance and adults with severe and persistent mental illness whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. (3-19-07)

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. (3-19-07)

10. Tasks. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - PARTICIPANT ELIGIBILITY.

To qualify for Enhanced Outpatient Mental Health Services, a participant must obtain a Comprehensive Assessment as described in Section 113 of these rules. The comprehensive assessment for PSR, Partial Care, and Psychotherapy must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. (7-1-06)T

01. General Participant Criteria. In order for a participant to be eligible for Enhanced Outpatient Mental Health services, the following criteria must be met and documented: (3-19-07)

- a.** Other services have failed or are not appropriate for the clinical needs of the participant. (3-19-07)
- b.** The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (7-1-06)T
- c.** Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in Enhanced Outpatient Mental Health services: (7-1-06)T
 - i.** Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (7-1-06)T
 - ii.** Participants needing more restrictive care or inpatient care; and (7-1-06)T
 - iii.** Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (7-1-06)T

02. Eligibility Criteria for Children. To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED). 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. (7-1-06)T

- a.** Presence of an emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and (7-1-06)T
- b.** Requires sustained treatment interventions; and (3-19-07)
- c.** Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-19-07)
- d.** A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (3-19-07)

03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI) as defined in Volume 58 of the Federal Register, 29422-02, June 24, 1999. (7-1-06)T

- a.** Currently or at any time during the year, he must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and (7-1-06)T
- b.** He must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. An adult who met the functional impairment criteria during the past year without

the benefit of treatment or other support services is considered to have a serious mental illness. (7-1-06)T

04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (7-1-06)T

a. Children must meet Subsections 112.01 and 112.02 of this rule. (7-1-06)T

b. Adults must meet Subsections 112.01 and 112.03 of this rule. (7-1-06)T

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Agencies and Partial Care Services for Children. To be eligible for the services of PSR or Partial Care, a child must meet the criteria of SED and Subsection 112.04.a. of this rule and must experience a 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 in Subsections 112.05.a. through 112.05.c. of this rule. (7-1-06)T

a. Self-harmful behavior; (7-1-06)T

b. Moods/Emotions; or (7-1-06)T

c. Thinking. (7-1-06)T

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Agencies and Partial Care Services for Adults. To be eligible for services of PSR or Partial Care, an adult must meet the criteria of SMI and Subsection 112.04.b. of this rule. In addition, the following criteria in Subsections 112.06.a. and 112.06.b. of this rule must be met. (7-1-06)T

a. The participant must have a diagnosis under DSM-IV-TR, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis; and (7-1-06)T

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 in Subsection 112.05.b.i. through 112.05.b.viii. of this rule on either a continuous or an intermittent, at least once per year, basis: (7-1-06)T

i. Vocational/educational; (7-1-06)T

ii. Financial; (7-1-06)T

iii. Social relationships/support; (7-1-06)T

iv. Family; (7-1-06)T

v. Basic living skills; (7-1-06)T

vi. Housing; (7-1-06)T

vii. Community/legal; or (7-1-06)T

viii. Health/medical. (7-1-06)T

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for 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 and submitted to the Department for prior authorization within ten (10) days of discharge. (7-1-06)T

i. Up to two (2) hours of plan development hours may be for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based 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 113.01 of these rules. (3-19-07)

ii. 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 129 of these rules must be met by the provider agency. (3-19-07)

b. A mental health clinic may serve a participant with Enhanced Plan services following a psychiatric hospitalization after a comprehensive assessment has been completed. The assessment must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule, and is appropriate for the participant's age and level of care that is medically necessary. The mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. (7-1-06)T

113. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - COMPREHENSIVE ASSESSMENT.

In order to determine eligibility for Enhanced Outpatient Mental Health services, a comprehensive assessment must first be completed. 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 medical record. The assessment is reimbursable if conducted by qualified PSR provider agency staff listed under Section 131 of these rules, or qualified Mental Health Clinic staff listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 715. Each of the following areas must be assessed initially and at least annually thereafter. (3-19-07)

01. Psychiatric History and Current Mental Status. Psychiatric history and current mental status which includes, at a minimum: (3-19-07)

a. Diagnosis documented within the last twelve (12) months in a face to face evaluation by a licensed physician or other licensed practitioner of the healing arts, licensed master's level psychiatric nurse, licensed psychologist, licensed clinical professional counselor, licensed marriage and family therapist, or licensed clinical social worker within the scope of his practice under state law; (3-19-07)

b. Age of the participant at onset; (3-19-07)

c. Childhood history of physical or sexual abuse; (3-19-07)

d. Number of hospitalizations; (3-19-07)

e. Precursors of hospitalizations; (3-19-07)

f. Symptoms of decompensation the participant manifests; (3-19-07)

g. Participant's ability to identify his symptoms; (3-19-07)

- h.** Medication history; (3-19-07)
- i.** Substance abuse history; (3-19-07)
- j.** History of mental illness in the family; (3-19-07)
- k.** Current mental status; and (3-19-07)
- l.** Any other information that contributes to the assessment of the participant's current psychiatric status. (3-19-07)

02. Health or Medical Issues. 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 or needs, current medications, name of current primary physician; health or medical issues or both including medical complications that result from mental illness. (3-19-07)

03. Vocational And Educational Status. Vocational and 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. (3-19-07)

04. Financial Status. 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. (3-19-07)

05. Social Relationships and Supports. Social relationships and supports 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. (3-19-07)

06. Family Status. 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. (3-19-07)

07. Basic Living Skills. Basic living skills which include at a minimum, participant's ability to meet age appropriate basic living skills including transition to adulthood. (3-19-07)

08. Housing. 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. (3-19-07)

09. Community and Legal Status. Community and 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. (3-19-07)

114. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.

A written individualized treatment plan must be developed and implemented for each participant of Enhanced Mental Outpatient Health Services as a means to address the enhanced service needs of the participant. Each Individualized Treatment Plan must specify the amount, frequency and expected duration of treatment. (3-19-07).

01. Goals. Services identified on the treatment plan must support the goals of any of the following as applicable to the participant's identified needs: (3-19-07)

a. PSR. The goal is the maximum reduction of mental disability and achievement of the highest possible functioning level of 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.
(3-19-07)

b. Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment.
(3-19-07)

c. Psychotherapy. The goal is to develop and implement psychotherapeutic strategies for problem resolution.
(3-19-07)

02. Plan Content. An individualized treatment plan must include the following, at a minimum:
(3-19-07)

a. An issue statement specifically describing the participant's behavior that directly relates to his mental illness and functional impairment;
(3-19-07)

b. A statement which identifies the participant's goal relative to the goals of Enhanced Outpatient Mental Health Services as per Sections 120 of these rules;
(3-19-07)

c. Overall goals 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 Enhanced Outpatient Mental Health Services;
(3-19-07)

d. 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; and
(3-19-07)

e. 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.
(3-19-07)

03. Plan Timeframes. An individualized treatment plan must be developed and signed by a physician or a licensed practitioner of the healing arts within thirty (30) calendar days from initial contact.
(3-19-07)

04. Annual Review. 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.
(3-19-07)

05. Physician Review. Each individualized treatment plan must be reviewed and signed by a physician or a licensed practitioner of the healing arts at least annually. Treatment plans developed by a Mental Health Clinic must be signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO).
(3-19-07)

06. Date of Plan. Following the completion of the comprehensive assessment and the date the plan is established, that date continues to be the annual date of the plan. Mental health clinics and PSR provider agencies serving the same participant must coordinate services such that the annual review date occurs on the same anniversary date.
(3-19-07)

07. Choice of Providers. The eligible participant will be allowed to choose whether or not he desires to receive Enhanced Outpatient Mental Health 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 medical record showing that the participant has been informed of his rights to refuse services and choose providers. (3-19-07)

08. Authorization Time Period. PSR Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. (3-19-07)

09. No Duplication of Services. The provider agency or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to Enhanced Outpatient Mental Health Services participants through other Medicaid reimbursable and non-Medicaid programs. (3-19-07)

115. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - MENTAL HEALTH CLINICS (MHC).

All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718 apply to Mental Health Clinic services in this chapter with the following enhancements. (3-19-07)

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to thirty-six (36) hours per week per eligible participant. (3-19-07)

a. In order to be considered a Partial Care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be a needed service as indicated through the comprehensive assessment in Section 113 of these rules and Section 114 of these rules on the individualized treatment plan with documented, concrete, and measurable goals and outcomes; and (3-19-07)

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. (3-19-07)

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. (3-19-07)

116. - 119. (RESERVED).

120. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).

Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department 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 IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 850. (3-19-07)

121. -- 122. (RESERVED).

123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - 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.

PSR consists of the following services described in Subsections 123.01 through 123.08 of this rule. (1-1-08)T

01. 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. (3-19-07)

02. 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 131 of these rules. Individual PSR includes one (1) or more of the following: (3-19-07)

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; (3-19-07)

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; (3-19-07)

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the participant's mental illness; (3-19-07)

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; (3-19-07)

e. Assisting the participant with receiving necessary services when he has difficulty or is unable to obtain them. (3-19-07)

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. (3-19-07)

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 131.01 of these rules, 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; (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

03. 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 131 of these rules. This service includes one (1) or more of the following: (3-19-07)

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; (3-19-07)

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; (3-19-07)

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-19-07)

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 (3-19-07)

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. (3-19-07)

04. Crisis Intervention Service. Crisis support 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 131 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. (1-1-08)T

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (3-19-07)

b. Crisis Support in an Emergency Department. (3-19-07)

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. (3-19-07)

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant. (3-19-07)

05. Collateral Contact. Collateral contact, as defined in Section 010 of these rules, is covered by Medicaid if it is included on the individualized treatment plan and it is necessary to gather and exchange information, provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons, or advise them how to assist the participant. (1-1-08)T

a. Collateral contact may be provided face-to-face by agency staff qualified to deliver services. Face-

to-face contact is defined as two (2) people meeting in person at the same time; or (1-1-08)T

b. Collateral contact may be provided by telephone by agency staff qualified to deliver services, when this is the most expeditious and effective way to exchange information. (1-1-08)T

06. Nursing Service. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402, Idaho Code. This may include supervision, monitoring, and administration of medications. (3-19-07)

07. Psychotherapy. Individual, group, and family psychotherapy must be prior authorized and provided in accordance with the objectives specified in the written individualized treatment plan, as described in Section 114 of these rules. Staff qualified to deliver psychotherapy and qualified supervisors of psychotherapy are identified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718. (1-1-08)T

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections 131.11 and 140.08 of these rules. (1-1-08)T

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR services, unless otherwise authorized by the Department in each region. (3-19-07)

01. Assessment. Any combination of evaluations or diagnostic services is limited to a maximum of six (6) hours annually. (3-19-07)

02. Individualized Treatment Plan. Two (2) hours per year per participant per provider agency are available for treatment plan development. (3-19-07)

03. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (3-19-07)

04. 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 123.04 of these rules. (1-1-08)T

05. Psychosocial Rehabilitation. Any combination of PSR services excluding crisis hours are not to exceed twenty (20) hours per week and must be prior authorized by the Department. Services in excess of twenty (20) hours require additional review and prior authorization. (3-19-07)

06. Place of Service. PSR services are to be home and community-based. (3-19-07)

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. (3-19-07)

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 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. (3-19-07)

c. Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856. (3-19-07)

125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.

Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (3-19-07)

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.09 of these rules. (3-19-07)

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose. (3-19-07)

03. Employment. Job-specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (3-19-07)

04. Household Tasks. Staff performance of household tasks and chores. (3-19-07)

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant. (3-19-07)

06. Participant Staffing Within an Agency. A participant staffing between two (2) staff who both provide PSR services within the same agency is not reimbursable. A participant 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. (3-19-07)

07. Medication Drops. Delivery of medication only; (3-19-07)

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (3-19-07)

09. Transportation. The provision of transportation services and staff time to transport. (3-19-07)

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (3-19-07)

11. Services Not Listed. Any other services not listed in Section 123 of these rules. (3-19-07)

126. -- 127. (RESERVED).

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RESPONSIBILITIES OF THE DEPARTMENT.

The Department will administer the provider agreement for the provision of PSR services and is responsible for the following tasks: (3-19-07)

01. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712. (3-19-07)

02. Individualized Treatment Plan Requirements. Individualized treatment plans must include the following: (3-19-07)

a. Required Documentation. The required documentation for each individualized treatment plan includes: (3-19-07)

i. Participant demographic information; (3-19-07)

ii. A comprehensive assessment as provided in Section 113 of these rules; (1-1-08)T

iii. A written individualized treatment plan as provided in Section 114 of these rules; (1-1-08)T

- iv. Adult treatment plans require a mental health client profile; and (3-19-07)
- v. Children's individualized treatment plans also require the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). (3-19-07)
- b. **Receipt of Required Documentation.** Reimbursement for services will be authorized from the date the individualized treatment plan and other required documentation are received by the Department. For the annual update, all required documentation must be received by the Department 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 136.05 of these rules. (3-19-07)
- c. **Hours and Type of Service.** The Department 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. (3-19-07)
- d. **Authorization Time Period.** Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. (3-19-07)
- 03. Notice of Decision.** At the point the Department makes a decision 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. (3-19-07)
- 04. Increases in Individualized Treatment Plan Hours or Change in Service Type.** When the Department is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department must review the request and either approve or deny the request within ten (10) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. (3-19-07)
- 05. Changes to Individualized Treatment Plan Objectives or Tasks.** When a provider believes that an individualized treatment plan needs to be revised without increasing hours or changing type of service, the provider should amend the individualized treatment plan at the time of the next one hundred twenty-day (120) review or when substantial changes in the participant's mental status or circumstances require immediate changes in the plan objectives. The amended individualized treatment plan must be retained in the participant's record and submitted to the Department upon request. (3-19-07)
- 06. Service System.** The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (3-19-07)
- 129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER RESPONSIBILITIES**
- 01. Provider Agreement.** Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR services and also is responsible for the following tasks: (3-19-07)
- 02. Service Provision.** Each provider must have signed additional terms to the general provider agreement with the Department. (3-19-07)
- 03. Service Availability.** Each provider must assure provision of PSR services to participants on a twenty-four (24) hour basis. (3-19-07)
- 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 if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to

meet the participant's identified needs. (3-19-07)

05. Individualized Treatment Plan. The provider must develop an individualized treatment plan in accordance with Section 114 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 initial plan is the date it is signed by the physician. Reimbursement for services will be authorized according to Subsection 128.02.b. of these rules. (3-19-07)

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. (3-19-07)

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. (3-19-07)

08. Healthy Connections Referral. Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program. (3-19-07)

130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER AGENCY REQUIREMENTS.

Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements: (3-19-07)

01. Agency. A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both 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. (3-19-07)

02. Criminal History Checks. (3-19-07)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." (3-19-07)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (3-19-07)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (3-19-07)

03. PSR Agency Staff Qualifications. The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules. (3-19-07)

04. Additional Terms. The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what PSR services must be provided by the agency. The agency's additional terms may be revised or cancelled at any time. (3-19-07)

05. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (3-19-07)

06. Supervision. The agency must provide staff with adequate supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. Individuals in Subsection 131.08 through 131.12 of these rules must be supervised by

individuals in Subsection 131.01 through 131.07 of these rules. (3-19-07)

a. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)

b. An agency must assure clinical supervision is available to all staff that provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)

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. (3-19-07)

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. (3-19-07)

09. Building Standards, Credentialing and Ethics. PSR Agencies must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 712 and 714. (3-19-07)

131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - AGENCY STAFF QUALIFICATIONS. All agency staff delivering PSR services must meet at least one (1) of the following qualifications: (3-19-07)

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. (3-19-07)

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. (3-19-07)

03. Licensed Psychologist. A psychologist must be licensed in accordance with Title 54, Chapter 23, Idaho Code. (3-19-07)

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." (3-19-07)

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." (3-19-07)

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." (3-19-07)

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. (3-19-07)

08. 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." (3-19-07)

09. Licensed Professional Nurse (RN). A licensed professional nurse or RN, must be licensed in accordance with Title 54, Chapter 14, Idaho Code. (3-19-07)

10. 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 131.01 through 131.10 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. (3-19-07)

11. 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. (3-19-07)

12. 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. (3-19-07)

132. -- 135. (RESERVED).

136. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RECORD REQUIREMENTS FOR PROVIDERS.

In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (3-19-07)

01. Name. Name of participant. (3-19-07)

02. Provider. Name of the provider agency and the agency staff person delivering the service. (3-19-07)

03. Date, Time, Duration of Service, and Justification. Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (3-19-07)

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (3-19-07)

05. 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. (3-19-07)

a. A copy of the review must be sent to the Department upon request. Failure to do so may result in the loss of a prior authorization or result in a recoupment of reimbursement provided for services delivered after the one hundred twenty (120) day review due date. (3-19-07)

b. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring functional impairment. (3-19-07)

c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (3-19-07)

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (3-19-07)

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (3-19-07)

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (3-19-07)

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments 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. (3-19-07)

137. - 139. (RESERVED).

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER REIMBURSEMENT. Payment for PSR services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (3-19-07)

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple PSR staff are present. (3-19-07)

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)

06. Evaluations and Tests. Evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (3-19-07)

07. Psychological Evaluations. Psychological evaluations are reimbursable if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718. (3-19-07)

08. Evaluations by Occupational Therapists. Evaluations performed by qualified licensed occupational therapists, performed in conjunction with development of an individualized treatment plan are reimbursable. (3-19-07)

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. (3-19-07)

10. Reimbursement for Services Provided in a School. PSR Services provided by a PSR agency in a school-based setting, must be billed by the school district, charter school, or the Idaho Infant Toddler program. (3-19-07)

141. - 145. (RESERVED).

146. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - QUALITY OF SERVICES.

The Department must monitor the quality and outcomes of PSR services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Behavioral Health. (3-19-07)

147. -- 199. (RESERVED).

SUB AREA: ENHANCED HOME HEALTH CARE

(Sections 200 Through 214)

200. PRIVATE DUTY NURSING SERVICES.

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. Sections 200 through 209 of these rules cover requirements for private duty nursing services. (3-19-07)

201. PRIVATE DUTY NURSING - DEFINITIONS.

The following definitions apply to Sections 200 through Section 209 of these rules. (3-19-07)

01. Primary RN. The RN identified by the family to be responsible for development, implementation, and maintenance of the Medical Plan of Care. (3-19-07)

02. Private Duty Nursing (PDN) RN Supervisor. An RN providing oversight of PDN services delegated to LPN's providing the child's care, in accordance with IDAPA 23.01.01, "Rules of the Board of Nursing." (3-19-07)

202. PRIVATE DUTY NURSING - ELIGIBILITY.

To be eligible for Private Duty Nursing (PDN), 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 prior to delivery of service. (3-19-07)

203. PRIVATE DUTY NURSING - FACTORS ASSESSED FOR ELIGIBILITY AND REDETERMINATION.

Factors assessed for eligibility/redetermination include: (3-19-07)

01. Age for Eligibility. The individual is under the age of twenty - one (21) years. (3-19-07)

02. Maintained in Personal Residence. That the child is being maintained in their personal residence and receives safe and effective services through PDN services. (3-19-07)

03. Medical Justification. The child receiving PDN services has medical justification and physician's orders. (3-19-07)

04. 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. (3-19-07)

05. 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. (3-19-07)

06. Redetermination. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: (3-19-07)

a. Determine if the child continues to meet the PDN criteria in Subsection 203.01 through 203.05 of these rules; and (3-19-07)

b. Assure that services and care are medically necessary and appropriate. (3-19-07)

204. PRIVATE DUTY NURSING - COVERAGE AND LIMITATIONS.

PDN services are functions 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." (3-19-07)

01. Ordered by a Physician. PDN Services must be ordered by a physician and include: (3-19-07)

a. 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 (3-19-07)

b. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes an evaluation of the child's responses to interventions or medications. (3-19-07)

02. Plan of Care. PDN Services must include a Plan of Care. The plan of care must: (3-19-07)

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; (3-19-07)

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; (3-19-07)

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; and (3-19-07)

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 for review and prior authorization of service. (3-19-07)

03. Status Updates. 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. (3-19-07)

04. Limitations. 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: (3-19-07)

a. Licensed Nursing Facilities (NF); (3-19-07)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); (3-19-07)

c. Residential Care or Assisted Living Facilities; (3-19-07)

d. Licensed hospitals; and (3-19-07)

e. Public or private school. (3-19-07)

205. - 208. (RESERVED).

209. PRIVATE DUTY NURSING - PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary RN Responsibility For PDN Redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department 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 204.02 of these rules. (3-19-07)

02. Physician Responsibilities. Physician responsibilities include: (3-19-07)

a. Medical Information. Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. (3-19-07)

b. Order Services. Order all services to be delivered by the private duty nurse. (3-19-07)

c. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. (3-19-07)

d. 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 and facilitate the admission of the child to the appropriate medical facility. (3-19-07)

03. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include: (3-19-07)

a. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery; (3-19-07)

b. Notify the Department 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; (3-19-07)

c. Evaluate changes of condition; (3-19-07)

d. Provide services in accordance with the nursing care plan; and (3-19-07)

e. Must ensure copies of records are maintained in the child's home. Records of care must include: (3-19-07)

i. The date; (3-19-07)

ii. Time of start and end of service delivery each day; (3-19-07)

iii. Comments on child's response to services delivered; (3-19-07)

iv. Nursing assessment of child's status and any changes in that status per each working shift; (3-19-07)

v. Services provided during each working shift; and (3-19-07)

vi. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department. (3-19-07)

04. 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 IDAPA 23.01.01, "Rules of the Board of Nursing." RN Supervisor visits must occur at least once every thirty (30) days when services are provided by an LPN. (3-19-07)

05. Ensure Health and Safety of Children. PDN providers must 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. (3-19-07)

210. - 214. (RESERVED).

SUB AREA: THERAPIES

(Sections 215 Through 219)

215. PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY SERVICES.

In addition to the providers listed at IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 730 through 738, physical, speech, and occupational therapy services are covered under these rules when provided by a Developmental Disabilities Agencies. (3-19-07)

216. - 219. (RESERVED).

SUB AREA: LONG-TERM CARE

(Sections 220 Through 330)

220. NURSING FACILITY.

The Enhanced Plan Benefit includes nursing facilities services permitted under Section 1905(a)(4)(A) of the Social Security Act. These services include nursing facilities services (other than services in an institution for mental diseases) for individuals determined to be in need of such care. (3-19-07)

221. (RESERVED).

222. NURSING FACILITY SERVICES - ELIGIBILITY.

Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Department has determined that the individual meets the criteria for nursing facility services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (4-1-07)T

01. Criteria for Determination. The criteria for determining a medical assistance participant's need for nursing facility care is described in Section 223. In addition, the Inspection of Care/Utilization Control (IOC/UC) nurse must determine whether a medical assistance participant's needs could be met by alternatives other than residing in a nursing facility, such as an independent living arrangement or residing in a room and board situation. (3-19-07)

a. The participant can select any certified facility to provide the care required. (3-19-07)

b. The final decision as to the level of care required by a medical assistance participant must be made by the IOC/UC Nurse. (3-19-07)

c. The final decision as to the need for developmental disability (DD) or mental illness (MI) active treatment must be made by the appropriate Department staff as a result of the Level II screening process. (3-19-07)

d. No payment will be made by the Department on behalf of any eligible medical assistance participant to any long-term care facility which, in the judgment of the IOC/UC Team, is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (3-19-07)

02. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field

Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. (3-19-07)

223. NURSING FACILITY - CRITERIA FOR DETERMINING NEED.

The participant requires nursing facility level of care when an adult meets one (1) of the Resource Utilization Group (RUG III) classifications or when a child meets one (1) or more of the criteria described in Subsections 223.02, 223.03, 223.04 or 223.05 of this rule. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years of age. (4-1-07)T

01. Required Assessment for Adults. A standard assessment will be approved by the Department for all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. (4-1-07)T

02. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-19-07)

03. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (3-19-07)

04. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-19-07)

05. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.02, 223.03, and 223.04 of these rules, plus consideration of the developmental milestones, based on the age of the child, the Department's RMS will determine nursing facility level of care. (4-1-07)T

06. Conditions of Payment. (3-19-07)

a. As a condition of payment by the Department for long-term care on behalf of medical assistance participants, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. (3-19-07)

b. Payment by the Department for the cost of long-term care is to include the date of the participant's discharge only if the discharge occurred after 3:00 p.m. (3-19-07)

224. NURSING FACILITY - POST-ELIGIBILITY TREATMENT OF INCOME.

Where an individual is determined eligible for medical assistance 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 IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Sections 721 through 726. The amount which the medical assistance participant 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 under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Section 317. (3-19-07)

225. NURSING FACILITY SERVICES - COVERAGE AND LIMITATIONS.

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. (3-19-07)

01. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following: (3-19-07)

a. Room and board; (3-19-07)

- b.** Bed and bathroom linens; (3-19-07)
- c.** Nursing care, including special feeding if needed; (3-19-07)
- d.** Personal services; (3-19-07)
- e.** Supervision as required by the nature of the patient's illness; (3-19-07)
- f.** Special diets as prescribed by a patient's physician; (3-19-07)
- g.** 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; (3-19-07)
- h.** Dressings; (3-19-07)
- i.** Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (3-19-07)
- j.** Application or administration of all drugs; (3-19-07)
- k.** 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 disposable gloves; (3-19-07)
- l.** Social and recreational activities; and (3-19-07)
- m.** Items which are utilized by individual patients but which are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (3-19-07)

02. Skilled Services. Skilled services include services which could qualify as either skilled nursing or skilled rehabilitative services, which include: (3-19-07)

a. 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 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. (3-19-07)

b. 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. (3-19-07)

03. Direct Skilled Nursing Services. Direct skilled nursing services include the following: (3-19-07)

- a.** Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; (3-19-07)
- b.** Nasopharyngeal feedings; (3-19-07)
- c.** Nasopharyngeal and tracheotomy aspiration; (3-19-07)

- d.** Insertion and sterile irrigation and replacement of catheters; (3-19-07)
- e.** Application of dressings involving prescription medications or aseptic techniques; (3-19-07)
- f.** Treatment of extensive decubitus ulcers or other widespread skin disorders; (3-19-07)
- 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 (3-19-07)
- h.** Initial phases of a regimen involving administration of oxygen. (3-19-07)

04. Direct Skilled Rehabilitative Services. Direct skilled rehabilitative services include the following: (3-19-07)

- a.** 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; (3-19-07)
- b.** 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; (3-19-07)
- c.** 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 (3-19-07)
- d.** Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. (3-19-07)

05. Other Treatment and Modalities. Other treatment and modalities which include 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. (3-19-07)

226. NURSING FACILITY - PROCEDURAL RESPONSIBILITIES.

01. Nursing Facility Responsibility. Each nursing facility administrator, or his authorized representative must report the following information to the appropriate RMS within three (3) working days of the date the facility has knowledge of the following. (3-19-07)

- a.** Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (3-19-07)
- b.** Any changes in the amount of a participant's income. (3-19-07)
- c.** When a participant's account has exceed the following amount; (3-19-07)
 - i.** For a single individual, one thousand eight hundred dollars (\$1,800);or (3-19-07)
 - ii.** For a married couple, two thousand eight hundred dollars (\$2,800). (3-19-07)

02. Other Financial Information for Participant. Other information about a participant's finances which may potentially affect eligibility for medical assistance must be reported if the nursing facility has any knowledge of the participant's financial information. (3-19-07)

227. PREADMISSION SCREENING AND ADDITIONAL RESIDENT REVIEW PROGRAM (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, (PASARR) as set forth in 42 CFR, Part 483, Subpart C. (3-19-07)

01. 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 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 requires the level of services provided by a nursing facility. If the individual with MI or MR is determined to require a nursing facility level of care, it must also be determined whether the individual requires specialized services. PASARR applies to all individuals entering or residing in a nursing facility, regardless of payment source. (3-19-07)

02. Policy. It is the policy of the Department that the difficulty in providing specialized services in the nursing facility setting makes it generally inappropriate to place individuals needing specialized services in a nursing facility. This policy is supported by the background and development of the federal PASARR requirements, including the narrow definition of mental illness adopted by federal law. While recognizing that there are exceptions, it is envisioned that most individuals appropriate for nursing facility placement will not require services in excess of those required to be provided by nursing facilities by 42 CFR 483.45. (3-19-07)

03. 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. (3-19-07)

a. The "State Mental Health Authority" (SMHA) in the Division of Family and Community Services of the Department, or its successor entity. (3-19-07)

b. The "State Mental Retardation or Developmental Disabilities Authority" (SDDA) in the Division of Family and Community Services of the Department, or its successor entity. (3-19-07)

04. Coordination for PASARR. The PASARR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and the nursing facility. PASARR activities will be coordinated through the Regional Medicaid Services (RMS). RMS is responsible for record retention and tracking functions. However, the nursing facility is responsible for assuring that all screens are obtained and for coordination with the RMS, independent MI evaluators, the SMHA and SDDA, and their designees. Guidelines and procedures on how to comply with these requirements can be found in the "Statewide PASARR Procedures," a reference guide. (3-19-07)

a. All required Level I screens and reviews must be completed and submitted to the RMS prior to admission to the facility. (3-19-07)

b. When a nursing facility identifies an individual with MI or MR through a Level I screen, or otherwise, the nursing facility is responsible for contacting the SMHA or SDDA (as appropriate), 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. (3-19-07)

c. Additional Resident Reviews (ARR). An individual identified with MI or MR must be reviewed and a new determination made promptly after a significant change in his physical or mental condition. The facility must notify the RMS of any such change within two (2) working days of its occurrence. For the purpose of this section, significant change for the participant'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 participant incapable of responding to MI or D.D. program interventions. (3-19-07)

228. NURSING FACILITY - COORDINATION OF NURSING FACILITY ELIGIBILITY AND THE NEED FOR SPECIALIZED SERVICES.

Determinations as to the need for nursing facility 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 the 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 nursing facility, the nursing facility is responsible for meeting that individual's needs, except for the provision of specialized services. (3-19-07)

01. Level of Care. (3-19-07)

a. Individual determinations must be based on evaluations and data as required by these rules. (3-19-07)

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 nursing facility 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. (3-19-07)

02. 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. (3-19-07)

a. Individual determinations must be based on evaluations and data as required by these rules. (3-19-07)

b. Categorical determinations that specialized services are not needed may be made in those situations permitted by 42 CFR 483.130. (3-19-07)

03. Penalty for Non-Compliance. No payment will be made for any services rendered by a nursing facility 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 nursing facility to other penalties as part of certification action under 42 CFR 483.20. (3-19-07)

04. Appeals. Discharges, transfers, and preadmission PASARR determinations may be appealed to the extent required by 42 CFR, Part 483, Subpart E, and under Section 67-5229, Idaho Code. Appeals under this paragraph are made in accordance with the fair hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

a. 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. (3-19-07)

b. In the event that the PASARR program is eliminated or made non-mandatory by an act of Congress, the provisions of Section 227 of these rules will cease to be operative on the effective date of any such act, without further action. (3-19-07)

229. NURSING FACILITY - PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NURSING FACILITY CARE AND SERVICES.

The level of care for Title XIX and Title XXI payment purposes is determined by the Department. 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 RMS will not be earlier than the date the Level II screen is completed, indicating that nursing

facility placement is appropriate. (4-1-07)T

01. Information Required for Medical Evaluation Determination. A current Minimum Data Set (MDS) assessment will be provided to the Department. Additional supporting information may be requested. (3-19-07)

02. Information Required for Level I and II Screen Determination. An accurate Level I screen and when required, a Level II screen. (3-19-07)

230. NURSING FACILITY - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as a nursing facility. (3-19-07)

02. Licensure and Certification. (3-19-07)

a. Upon receipt of an application from a facility, the Licensing and Certification Agency determines the facility's compliance with certification standards for the type of care the facility proposes to provide to medical assistance participants. (3-19-07)

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. (3-19-07)

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care. The Department must certify to the appropriate branch of government that the facility meets the standards for nursing facility level of care. (3-19-07)

d. Upon receipt of the certification from the Licensing and Certification Agency, the Department may enter into a provider agreement with the long-term care facility. (3-19-07)

e. After the provider agreement has been executed by the Facility Administrator and by the Department, one (1) copy must be sent by certified mail to the facility and the original is to be retained by the Department (3-19-07)

232. -- 234. (RESERVED).

235. NURSING FACILITY - PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of long term care is to include the date of the participant'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 will be deemed to exist. (3-19-07)

236. NURSING FACILITY - REASONABLE COST PRINCIPLES.

To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to participants will result. (3-19-07)

01. Application of Reasonable Cost Principles. (3-19-07)

a. Reasonable costs of any services are determined in accordance with this chapter of rules found in

Sections 236 through 295 of these rules, and Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (3-19-07)

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (3-19-07)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (3-19-07)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (3-19-07)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (3-19-07)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (3-19-07)

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (3-19-07)

03. Costs Not Related to Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (3-19-07)

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property. If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (3-19-07)

237. NURSING FACILITY - NOTICE OF PROGRAM REIMBURSEMENT.

Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. (3-19-07)

01. Notice. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. (3-19-07)

02. Recovery or Suspension. Such action of recovery or suspension will continue even after a request

for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-19-07)

03. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. (3-19-07)

04. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three-year (3) period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-19-07)

238. NURSING FACILITY - INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS. The Title XIX and Title XXI programs will charge interest on overpayments, and pay interest on underpayments. (3-19-07)

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement, and will be charged on the unpaid settlement balance for each thirty-day (30) period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty-day (30) period, and the thirty-day (30) interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (3-19-07)

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (3-19-07)

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. (3-19-07)

04. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only be applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. (3-19-07)

239. NURSING FACILITY - RECOVERY METHODS FOR OVERPAYMENTS. One (1) of the following methods will be used for recovery of overpayments: (3-19-07)

01. Lump Sum Voluntary Repayment. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (3-19-07)

02. Periodic Voluntary Repayment. The provider must request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. (3-19-07)

03. Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice. (3-19-07)

04. Recovery From Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR, Section 405.377. (3-19-07)

240. NURSING FACILITY - ALLOWABLE COSTS. The following definitions and explanations apply to allowable costs: (3-19-07)

01. Accounts Collection. The costs related to the collection of past due program related accounts, such

as legal and bill collection fees, are allowable. (3-19-07)

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (3-19-07)

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300. (3-19-07)

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (3-19-07)

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 274 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (3-19-07)

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (3-19-07)

b. Supplies and services provided for the owner's personal use. (3-19-07)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (3-19-07)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (3-19-07)

e. Keyman life insurance. (3-19-07)

f. Living expenses, including those paid for related persons. (3-19-07)

06. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (3-19-07)

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 275 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (3-19-07)

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (3-19-07)

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (3-19-07)

10. Employee Recruitment. Costs of advertising for new employees, including applicable

entertainment costs, are allowable. (3-19-07)

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (3-19-07)

12. Food. Costs of raw food, not including vending machine items, are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (3-19-07)

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (3-19-07)

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (3-19-07)

15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (3-19-07)

16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein. (3-19-07)

17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs. (3-19-07)

18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. (3-19-07)

19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For free-standing nursing facilities, the property rental rate is paid as described in Section 275 of these rules. Hospital-based nursing facilities are paid based on property costs. (3-19-07)

a. Amortization of leasehold improvements will be included in property costs. (3-19-07)

i Straight line depreciation on fixed assets is included in property costs. (3-19-07)

ii. Depreciation of moveable equipment is an allowable property cost. (3-19-07)

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (3-19-07)

20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (3-19-07)

21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (3-19-07)

22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (3-19-07)

23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable. (3-19-07)

24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (3-19-07)

241. NURSING FACILITY - NONALLOWABLE COSTS.

The following definitions and explanations apply to nonallowable costs: (3-19-07)

01. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (3-19-07)

02. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (3-19-07)

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (3-19-07)

04. Charity Allowances. Cost of free care or discounted services are nonallowable. (3-19-07)

05. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 236 or 245 of these rules, when applicable. (3-19-07)

06. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1. (3-19-07)

07. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (3-19-07)

08. Goodwill. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (3-19-07)

09. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (3-19-07)

10. Interest. Interest to finance nonallowable costs are nonallowable. (3-19-07)

11. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (3-19-07)

12. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable. (3-19-07)

13. Organization. Organization costs are nonallowable, see PRM, Section 2134. (3-19-07)

14. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable. (3-19-07)

15. Prescription Drugs. Prescription drug costs are nonallowable. (3-19-07)

16. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1

and 218.2. (3-19-07)

17. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (3-19-07)

18. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (3-19-07)

19. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, which apply to facility owners are nonallowable. (3-19-07)

20. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (3-19-07)

21. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (3-19-07)

242. NURSING FACILITY - HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (3-19-07)

243. NURSING FACILITY - RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (3-19-07)

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (3-19-07)

244. NURSING FACILITY - APPLICATION OF RELATED PARTY TRANSACTIONS.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (3-19-07)

a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (3-19-07)

b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. (3-19-07)

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (3-19-07)

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. (3-19-07)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. (3-19-07)

245. NURSING FACILITY - COMPENSATION OF RELATED PERSONS.

Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (3-19-07)

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (3-19-07)

a. Where such persons perform services without pay, no cost may be imputed. (3-19-07)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (3-19-07)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (3-19-07)

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (3-19-07)

a. Husband or wife; (3-19-07)

b. Son or daughter or a descendent of either; (3-19-07)

c. Brother, sister, stepbrother, stepsister or descendent thereof; (3-19-07)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (3-19-07)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (3-19-07)

f. A descendent of a brother or sister of the provider's father or mother; (3-19-07)

g. Any other person with whom the provider does not have an arms length relationship. (3-19-07)

246. NURSING FACILITY - INTEREST EXPENSE.

Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (3-19-07)

247. -- 249. (RESERVED).

250. NURSING FACILITY - COST LIMITS.

Sections 250 through 271 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999, are subject to rules in effect before July 1, 1999. (3-19-07)

251. (RESERVED).

252. NURSING FACILITY - PROPERTY AND UTILITY COSTS.

Whether or not each of these cost items is allowed will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (3-19-07)

01. Depreciation. All allowable depreciation expense. (3-19-07)

02. Interest. All allowable interest expense relating to financing building and equipment purchases.

Interest on working capital loans will be included as administrative costs. (3-19-07)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (3-19-07)

04. Lease Payments. All allowable lease or rental payments. (3-19-07)

05. Property Taxes. All allowable property taxes. (3-19-07)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (3-19-07)

253. -- 254. (RESERVED).

255. NURSING FACILITY - RATE SETTING.

The objectives of the rate setting mechanism for nursing facilities are: (3-19-07)

01. Payments. To make payments to nursing facilities through a prospective cost-based system which includes facility-specific case mix adjustments. (3-19-07)

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. (3-19-07)

256. NURSING FACILITY - PRINCIPLE FOR RATE SETTING.

Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (3-19-07)

257. NURSING FACILITY - DEVELOPMENT OF THE RATE.

Nursing facility rates are prospective, with new rates effective July 1st of each year, and rebased annually. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of these rules. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. (3-19-07)

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1 are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (3-19-07)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (3-19-07)

06. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component. (3-19-07)

07. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

08. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

09. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

258. NURSING FACILITY - COST LIMITS BASED ON COST REPORT.

Effective July 1, 1999, and each July 1st thereafter, cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year. (3-19-07)

01. Percentage Above Bed-Weighted Median. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (3-19-07)

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (3-19-07)

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits will not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward. (3-19-07)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

259. NURSING FACILITY - TREATMENT OF NEW BEDS.

Facilities that add beds after July 1, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. (3-19-07)

01. Limitation of Facilities Rate. The facility's rate will be limited to the bed-weighted average of the following two (2) rates: (3-19-07)

a. The facility's current prospective rate calculated in accordance with Section 257 of these rules; and (3-19-07)

b. The current median rate for nursing facilities of that type, free-standing, rural hospital-based, or urban hospital-based, established each July 1st. (3-19-07)

02. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate. (3-19-07)

03. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (3-19-07)

a. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed. (3-19-07)

b. Beds added as a result of expansion plans, which the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written

request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria. (3-19-07)

c. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department. (3-19-07)

d. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an under served area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the reimbursement rate is negotiated with the Department. (3-19-07)

260. NURSING FACILITY - TREATMENT OF NEW FACILITIES.

Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Section 257 of this rule. (3-19-07)

261. NURSING FACILITY - TREATMENT OF A CHANGE IN OWNERSHIP.

New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. (3-19-07)

262. NURSING FACILITY - OUT-OF-STATE NURSING HOMES.

The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the participant's medical need, or in a temporary situation for a limited period of time required to safely transport the participant to an Idaho facility. Reimbursement for out-of-state nursing homes will be at the per diem rate set by the Medicaid Program in the state where the nursing home is located. Special rates will be allowed according to Section 270 of these rules. (3-19-07)

263. NURSING FACILITY - DISTRESSED FACILITY.

If the Department determines that a facility is operationally or financially unstable, is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. (3-19-07)

264. NURSING FACILITY - INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.

Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: (3-19-07)

01. Changes of More Than Fifty Cents Per Patient Day in Costs. Changes of more than fifty cents (\$.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (3-19-07)

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (3-19-07)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (3-19-07)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (3-19-07)

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (3-19-07)

03. Future Treatment of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at its option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (3-19-07)

265. NURSING FACILITY - MDS REVIEWS.

The following Minimum Data Set (MDS) reviews will be conducted: (3-19-07)

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (3-19-07)

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (3-19-07)

266. -- 269. (RESERVED).

270. NURSING FACILITY - SPECIAL RATES.

A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Section 56-102, Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (3-19-07)

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than two (2) weeks. (3-19-07)

02. Effective Date. Upon approval, a special rate is effective on the date the application was received, unless the provider requests a retroactive effective date. Special rates may be retroactive for up to thirty (30) days prior to receipt of the application. (3-19-07)

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. (3-19-07)

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar

services. (3-19-07)

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of these rules provide clarification of how special rates are paid under the prospective payment system. (3-19-07)

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.e. of these rules. (3-19-07)

a. Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules. (3-19-07)

i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit. (3-19-07)

ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit. (3-19-07)

iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. (3-19-07)

iv. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (3-19-07)

v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. (3-19-07)

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not adequately addressed in the current RUG system, as determined by the Department, are reimbursed at invoice cost as an add-on amount. (3-19-07)

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care. In the case of ventilator dependent and tracheostomy residents, a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents. The add-on is calculated following the provisions in Subsection 270.06.d. of these rules, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment, supplies, or both up to the invoice cost or rental amount. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care.

(3-19-07)

d. Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios. If the resident qualifies for a special rate, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance of thirty percent (30%), then weighted to remove the CNA Minimum daily staffing time. (3-19-07)

e. Varying Levels of One-to-One Care. For varying levels of one-to-one care, such as eight (8) hours or twenty-four (24) hours, the total special rate add-on amount is calculated as the number of hours approved for one-to-one care times the hourly add-on rate as described in Subsection 270.06.d. The WAHR CNA wage rate as described in Section 307 of these rules will be updated prior to the July 1st rate setting each year. Should the WAHR survey be discontinued, the Department may index prior amounts forward, or conduct a comparable survey. (3-19-07)

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains non-unit special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs. (3-19-07)

271. NURSING FACILITY - OVERSIGHT COMMITTEE.

The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing free standing skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%)), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%)), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999). (3-19-07)

272. NURSING FACILITY - LEGAL CONSULTANT FEES AND LITIGATION COSTS.

Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (3-19-07)

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (3-19-07)

02. Administrative Appeals. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (3-19-07)

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (3-19-07)

273. NURSING FACILITY - PATIENT FUNDS.

The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the

administration of these funds requires scrupulous care in recording all transactions for the patient. (3-19-07)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (3-19-07)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (3-19-07)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (3-19-07)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (3-19-07)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (3-19-07)

03. Fund Management. Proper management of such funds would include the following as minimum: (3-19-07)

a. Savings accounts, maintained separately from facility funds. (3-19-07)

b. An accurate system of supporting receipts and disbursements to patients. (3-19-07)

c. Written authorization for all deductions. (3-19-07)

d. Signature verification. (3-19-07)

e. Deposit of all receipts of the same day as received. (3-19-07)

f. Minimal funds kept in the facility. (3-19-07)

g. As a minimum these funds must be kept locked at all times. (3-19-07)

h. Statement of policy regarding patient's funds and property. (3-19-07)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (3-19-07)

j. System of periodic review and correction of policies and financial records of patient property and funds. (3-19-07)

274. NURSING FACILITY - IDAHO OWNER-ADMINISTRATIVE COMPENSATION.

Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. (3-19-07)

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951

Licensed Bed Range	Upper limit
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

(3-19-07)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm.

(3-19-07)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 274.01 of these rules. Allowable compensation will be determined as follows:

(3-19-07)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility.

(3-19-07)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation.

(3-19-07)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 274.01 of these rules.

(3-19-07)

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner.

(3-19-07)

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners.

(3-19-07)

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080).

(3-19-07)

275. NURSING FACILITY - PROPERTY RENTAL RATE REIMBURSEMENT.

Free standing nursing facilities other than hospital based nursing facilities will be paid a property rental rate. Property taxes and property insurance will be reimbursed as costs exempt from limitations. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for free-standing nursing facilities, an interim rate for property reimbursement will be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code.

(3-19-07)

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 275.01 of these rules, and, beginning April 1, 1985, will be: (3-19-07)

R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (3-19-07)

a. "R" = the property rental rate. (3-19-07)

b. "Property Base" = thirteen dollars and nineteen cents (\$13.19) beginning October 1, 1996 for all freestanding nursing facilities. (3-19-07)

c. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, "change in building costs" will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding nursing facilities, the index available in September of the prior year will be used. (3-19-07)

d. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (3-19-07)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula: (3-19-07)

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 275.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (3-19-07)

ii. Historical nursing home construction cost per square foot for purposes of evaluating facility age.

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
1	2004	82.41	2	2003	80.80	3	2002	79.06
4	2001	78.43	5	2000	74.34	6	1999	71.55

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
7	1998	71.34	8	1997	68.20	9	1996	67.59
10	1995	66.19	11	1994	64.14	12	1993	60.56
13	1992	59.03	14	1991	56.13	15	1990	54.61
16	1989	53.17	17	1988	52.03	18	1987	51.66
19	1986	51.56	20	1985	50.55			

(3-19-07)

iii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 275.01.d.i. of these rules. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate “r” for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for “C” will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider’s responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs.

(3-19-07)

iv. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars (\$100) per bed. If the cost related to the requirement is less than one hundred dollars (\$100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility.

(3-19-07)

v. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 275.01.d.iii. and 275.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider.

(3-19-07)

vi. Effective July 1, 1991, for freestanding nursing facilities, “age of facility” will be a revised age which is the lesser of the age established under other provisions of this Section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under Subsection 275.01 of these rules. This revised age will not increase over time.

(3-19-07)

02. Grandfathered Rate. A “grandfathered property rental rate” for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985.

(3-19-07)

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, will be used to approximate the grandfathered rate.

(3-19-07)

b. The grandfathered property rental rate will be adjusted to compensate the facility for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985.

(3-19-07)

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i. of these rules. The grandfathered rate will be revised after completion of modifications and will be the greater of: (3-19-07)

i. The grandfathered rate previously allowed; or (3-19-07)

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate will be allowed to change that rate by more than three-fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. (3-19-07)

d. The facility will be reimbursed a rate which is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 275.02 of these rules or the property rental rate determined according to Subsections 275.01, 275.03, or 275.05 of these rules. (3-19-07)

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 275.01 and 275.02 of these rules. Provisions in this section do not apply to reimbursement of home office costs. Home office costs will be paid based on reasonable cost principles. (3-19-07)

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. (3-19-07)

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 275.01 or 275.02 of these rules. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. (3-19-07)

i. Effective July 1, 1989, the property rental rates of leased nursing facilities with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i. of these rules. The rate will be revised after the completion of such modifications and will be the greater of the property rental rate previously allowed under Subsection 275.03, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change will increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. (3-19-07)

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement will be at a rate per day of care which reflects the increase in the lease rate. (3-19-07)

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement will be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate will become the amount "R" determined by the formula in Subsection 275.01 of these rules as of the date on which the lease is or could be terminated. (3-19-07)

04. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive

the property rental rate of Subsection 275.01 of these rules, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner will be computed as if no sale had taken place. (3-19-07)

05. Forced Sale of a Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 275 of these rules, whichever is higher, but not exceeding the rate that would be due the seller. (3-19-07)

276. -- 277. (RESERVED).

278. NURSING FACILITY - OCCUPANCY ADJUSTMENT FACTOR.

In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (3-19-07)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (3-19-07)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (3-19-07)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (3-19-07)

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (3-19-07)

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (3-19-07)

279. NURSING FACILITY - RECAPTURE OF DEPRECIATION.

Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (3-19-07)

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (3-19-07)

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (3-19-07)

280. NURSING FACILITY - REPORTING SYSTEM.

The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (3-19-07)

- 01. Basis for Reimbursement.** A basis of provider reimbursement approximating actual costs. (3-19-07)
- 02. Disclosure.** Adequate financial disclosure. (3-19-07)
- 03. Statistical Resources.** Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (3-19-07)
- 04. Criteria.** Criteria for evaluating policies and procedures. (3-19-07)

281. NURSING FACILITY - REPORTING SYSTEM PRINCIPLE AND APPLICATION.

The provider will be required to file mandatory annual cost reports. (3-19-07)

- 01. Cost Report Requirements.** The fiscal year end cost report filing must include: (3-19-07)
 - a.** Annual income statement (two (2) copies); (3-19-07)
 - b.** Balance sheet; (3-19-07)
 - c.** Statement of ownership; (3-19-07)
 - d.** Schedule of patient days; (3-19-07)
 - e.** Schedule of private patient charges; (3-19-07)
 - f.** Statement of additional charges to residents over and above usual monthly rate; and (3-19-07)
 - g.** Other schedules, statements, and documents as requested. (3-19-07)
- 02. Special Reports.** Special reports may be required. Specific instructions will be issued, based upon the circumstance. (3-19-07)
- 03. Criteria of Reports.** All reports must meet the following criteria: (3-19-07)
 - a.** State approved formats must be used. (3-19-07)
 - b.** Presented on accrual basis. (3-19-07)
 - c.** Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (3-19-07)
 - d.** Appropriate detail must be provided on supporting schedules or as requested. (3-19-07)
- 04. Preparer.** It is not required that any statement be prepared by an independent, licensed or certified public accountant. (3-19-07)
- 05. Reporting by Chain Organizations or Related Party Providers.** PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to

the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (3-19-07)

06. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met: (3-19-07)

a. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the charge. This report must meet the criteria for annual cost reports, except that it must be filed not later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. (3-19-07)

b. The Department may require an appraisal at the time of a change in ownership. (3-19-07)

c. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report. (3-19-07)

282. NURSING FACILITY - REPORTING PERIOD.

For purposes of nursing facility rate setting, cost report periods of less than six (6) months will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is greater than six (6) months will be used until a cost report exceeding six (6) months is received from the new owner, or is based on the new fiscal year. (3-19-07)

283. NURSING FACILITY - FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (3-19-07)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (3-19-07)

284. NURSING FACILITY - FAILURE TO FILE.

Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (3-19-07)

285. NURSING FACILITY - ACCOUNTING SYSTEM.

Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (3-19-07)

286. NURSING FACILITY - AUDITS.

All financial reports are subject to audit by Departmental representatives. (3-19-07)

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (3-19-07)

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (3-19-07)

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (3-19-07)

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (3-19-07)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (3-19-07)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (3-19-07)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. (3-19-07)

08. Final Settlement. To effect final settlement when required by **Sections** 250 through 296 of these rules. (3-19-07)

287. NURSING FACILITY - AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (3-19-07)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (3-19-07)

03. Additional Audits. In addition, audits may be required where: (3-19-07)

a. A significant change of ownership occurs. (3-19-07)

b. A change of management occurs. (3-19-07)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (3-19-07)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (3-19-07)

288. NURSING FACILITY - AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (3-19-07)

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3, states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (3-19-07)

03. Examination of Records. Examination of records and documents may include: (3-19-07)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (3-19-07)

b. Minutes and memos of the governing body including committees and its agents. (3-19-07)

c. All contracts. (3-19-07)

- d.** Tax returns and records, including workpapers and other supporting documentation. (3-19-07)
- e.** All insurance contracts and policies including riders and attachments. (3-19-07)
- f.** Leases. (3-19-07)
- g.** Fixed asset records (see audit section - Capitalization of Assets). (3-19-07)
- h.** Schedules of patient charges. (3-19-07)
- i.** Notes, bonds and other evidences of liability. (3-19-07)
- j.** Capital expenditure records. (3-19-07)
- k.** Bank statements, cancelled checks, deposit slips and bank reconciliations. (3-19-07)
- l.** Evidence of litigations the facility and its owners are involved in. (3-19-07)
- m.** Documents of ownership including attachments which describe the property. (3-19-07)
- n.** All invoices, statements and claims. (3-19-07)
- o.** Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). (3-19-07)
- p.** Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (3-19-07)
- q.** All patient records, including trust funds and property. (3-19-07)
- r.** Time studies and other cost determining information. (3-19-07)
- s.** All other sources of information needed to form an audit opinion. (3-19-07)
- 04. Adequate Documentation.** (3-19-07)
 - a.** Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation which pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. (3-19-07)
 - b.** Adequate expenses documentation including an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (3-19-07)
 - i.** Date of service or sale; (3-19-07)
 - ii.** Terms and discounts; (3-19-07)
 - iii.** Quantity; (3-19-07)
 - iv.** Price; (3-19-07)
 - v.** Vendor name and address; (3-19-07)

- vi. Delivery address if applicable; (3-19-07)
- vii. Contract or agreement references; and (3-19-07)
- viii. Description, including quantity, sizes, specifications brand name, services performed. (3-19-07)
- c.** Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (3-19-07)
- d.** Completed depreciation records must meet the following criteria for each asset: (3-19-07)
 - i. Description of the asset including serial number, make, model, accessories, and location. (3-19-07)
 - ii. Cost basis should be supported by invoices for purchase, installation, etc. (3-19-07)
 - iii. Estimated useful life. (3-19-07)
 - iv. Depreciation method such as straight line, double declining balance, etc. (3-19-07)
 - v. Salvage value. (3-19-07)
 - vi. Method of recording depreciation on a basis consistent with accounting policies. (3-19-07)
 - vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (3-19-07)
 - viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (3-19-07)
- e.** Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (3-19-07)
- f.** The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition. Guidelines Lives, which is incorporated by reference under Section 004 of these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. (3-19-07)
- g.** Lease purchase agreements may generally be recognized by the following characteristics: (3-19-07)
 - i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (3-19-07)
 - ii. Intent to create security interest; (3-19-07)
 - iii. Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (3-19-07)
 - iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (3-19-07)
 - v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (3-19-07)
- h.** Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined

- in this chapter. Rental or lease payments will not be reimbursable. (3-19-07)
- i.** Complete personnel records normally contain the following: (3-19-07)
 - i. Application for employment. (3-19-07)
 - ii. W-4 Form. (3-19-07)
 - iii. Authorization for other deductions such as insurance, credit union, etc. (3-19-07)
 - iv. Routine evaluations. (3-19-07)
 - v. Pay raise authorization. (3-19-07)
 - vi. Statement of understanding of policies, procedures, etc. (3-19-07)
 - vii. Fidelity bond application (where applicable). (3-19-07)
 - 05. Internal Control.** (3-19-07)
 - a.** A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (3-19-07)
 - i. Safeguarding assets and resources against waste, fraud, and inefficiency. (3-19-07)
 - ii. Promoting accuracy and reliability in financial records. (3-19-07)
 - iii. Encouraging and measuring compliance with company policy and legal requirements. (3-19-07)
 - iv. Determining the degree of efficiency related to various aspects of operations. (3-19-07)
 - b.** An adequate system of internal control over cash disbursements would normally include: (3-19-07)
 - i. Payment on invoices only, or statements supported by invoices. (3-19-07)
 - ii. Authorization for purchase such as a purchase order. (3-19-07)
 - iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (3-19-07)
 - iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (3-19-07)
 - v. Check of invoice accuracy. (3-19-07)
 - vi. Approval policy for invoices. (3-19-07)
 - vii. Method of invoice cancellation to prevent duplicating payment. (3-19-07)
 - viii. Adequate separation of duties between ordering, recording, and paying. (3-19-07)
 - ix. System separation of duties between ordering, recording, and paying. (3-19-07)
 - x. Signature policy. (3-19-07)
 - xi. Pre-numbered checks. (3-19-07)
 - xii. Statement of policy regarding cash or check expenditures. (3-19-07)

- xiii. Adequate internal control over the recording of transactions in the books of record. (3-19-07)
- xiv. An imprest system for petty cash. (3-19-07)
- 06. Accounting Practices.** Sound accounting practices normally include the following: (3-19-07)
 - a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (3-19-07)
 - b. Chart of accounts. (3-19-07)
 - c. A budget or operating plan. (3-19-07)
- 289. (RESERVED).**
- 290. NURSING FACILITY - ANCILLIARY AND ROUTINE NURSING SUPPLIES.**
 - 01. Ancillary Supplies.**

Ancillary Supplies
Artificial Limbs
Canes
Laboratory Tests
Legend Drugs and Insulin paid to facilities on a patient and prescription specific basis
Radiology
X-ray

(3-19-07)

02. Routine Supplies.

Routine Supplies	
A	
A & D Ointment	Alcohol Applicators
ABD Pad	Arm Slings
Ace Bandages	Asepto Syringes
Acquamatic K Pads	Autoclave Sheets
Air Mattress	
B	
Baby Powder	Bed Pans
Band Aid Spots	Bedside Tissues
Band Aids	Benzoin Aerosol
Bandages/Elastic	Bibs

Routine Supplies	
Bandages/Sterile	Bottles/Specimen
Basins	Braces
Bed Frame Equipment	
C	
Cannula/Nasal	Clinitest
Catheter Clamp	Clysis Set
Catheter Plug	Coloplast
Catheter Tray	Cotton Balls
Catheters, any size	Crutches
Catheters/Irrigation	
D	
Decubitus Ulcer Pads	Douche Bags
Defecation Pads	Drainage Bags
Denture Cup	Drainage Sets
Deodorant	Drainage Tubing
Dermassage	Dressing/Sterile
Disposable Leg Bag	Dressing Tray
Disposable Underpads	Drugs Nonlegend
Donut Pad	
E	
Enema Cans/Disposable	Enema/Fleets in Oil
Enema/Fleets	
F	
Female Urinal	Flotation Mattress
Finger Cots	Foot Cradle
Flex Straws	
G	
Gastric Feeding Tube	Gloves/Sterile
Gloves/Nonsterile	Gowns
H	
Hand Feeding	Heel Protectors
Harris Flush Tube	Hexol
Heat Cradle	Hot Pack Machine
Heating Pad	

Routine Supplies	
I	
Ice Bag	Irrigation Bulb
Identification Bands	Irrigation Set
Incontinency Care	Irrigation Solution
Invalid Ring	Irrigation Tray
IPPB Machine	IV Set
J	
Jelly/Lubricating	
K	
Killet Ampules	Kling bandages/Sterile
Kleenex	KY Jelly
L	
Levine Tube	Lotion
Linen	
M	
Maalox	Medicine Dropper
Male Urinal	Merthiolate Spray
Massages	Milk of Magnesia
Medical Social Services	Mineral Oil
Medicine Cups	Mouthwashes
N	
Nasal Cannula	Needles
Nasal Catheter	Nonallergic Tape (paper tape)
Nasal Gastric Tube	Nursing Services
Nasal Tube	
O	
Occupational Therapy	Oxygen Equipment-IPPB
Ointment/Skin Nonprescription	Oxygen Mask/Disposable
Overhead Trapeze	Oxygen/Nondisposable
Oxygen	
P	
Peroxide	Physical Therapy (subject to Department policy)
Personal Laundry (except for dry cleaning and special laundry)	Plastic Bib

Routine Supplies	
Pitcher	Pumps (subject to Department policy)
R	
Rectal Tube	Room and Board
Restraints	
S	
Sand Bags	SStomach Tube
Scalpel	Suction Machines
Sheep Skin	Suppositories
Special Diets	Surgical Dressings
Specimen Cup	Surgical Pads
Speech Therapy	Surgical Tape/Nonallergic
Sponges/Sterile	Suture Set Suture Tray
Sterile Pads	Swabs/Lemon & Glycerin
T	
Tape (Lab-Testing)	Tracheostomy Sponges
Tape/Autoclave	Tray Service
Testing Sets/Refills	Tubing/IV
Thermometers	Tubing/Blood
Tincture of Benzoin	Tubing/Drainage
Tongue Blades	
U	
Urinals	Urological Solutions
Urinary Drainage Tube Underpads (if more than occasional use)	
V	
Vaseline	
W	
Walkers	Wheel Chairs
Water Pitchers	Water for Injection

(3-19-07)

291. NURSING FACILITY - COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS) AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.

Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as

follows: (3-19-07)

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, NATCEP costs will be outside the content of nursing facility care and will be reported separately as exempt costs. (3-19-07)

02. Costs Subject to Audit. Such NATCEP costs are subject to audit, and must be reported by all nursing facilities, including those that are hospital-based, and are not included in the percentile cap. (3-19-07)

292. NURSING FACILITY - PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE. Payments may be made for reserving beds in long-term care facilities for participants during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: (3-19-07)

01. 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: (3-19-07)

a. If licensed beds are less than one hundred (<100) and they have five (5) or more beds unoccupied, leave of absence payments are not allowed. (3-19-07)

b. If licensed beds are greater than or equal to one hundred (≥ 100), they must have a minimum occupancy rate of ninety-five percent (95%) for leave of absence payments to be allowed. (3-19-07)

02. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for therapeutic home visits for nursing facility 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. (3-19-07)

03. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following: (3-19-07)

i. Seventy-five percent (75%) of the audited allowable costs of the facility; or (3-19-07)

ii. The rate charged to private paying patients for reserve bed days. (3-19-07)

04. 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 on behalf of a medical assistance participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (3-19-07)

293. -- 294. (RESERVED).

295. NURSING FACILITY - UTILIZATION CONTROL REVIEWS. Selection of participants to be reviewed at least annually: (3-19-07)

01. Level II Participants. Participants who have a Level II evaluation, with the review completed within the quarter of the admission anniversary date; and (3-19-07)

02. Special Medicaid Rate. Participants who are receiving services that require a special Medicaid rate; and (3-19-07)

03. Selected Recertification. Participants identified during previous reviews whose improvement may remove the need for continuing nursing facility care. (3-19-07)

296. NURSING FACILITY - QUALITY INCENTIVES. Nursing facility providers that are recognized for providing high quality care, based on determinations by the agency of the Department that inspects and certifies such facilities for participation in the Medicaid program, will be eligible

for incentive payments. The amount of such payments and the basis therefore will be determined by the Director and will be paid in addition to any other payments for which the facility is eligible under other provisions of this chapter, including provisions related to limitations related to customary charges. However, such payments will be subject to available State and federal funds and will be postponed or omitted in the event that such payments along with other payments made to Nursing Facilities under this chapter would, in aggregate, exceed the estimated payments that would be made utilizing Medicare principles of cost reimbursement. (3-19-07)

297. -- 299. (RESERVED).

300. 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. (3-19-07)

301. (RESERVED).

302. PERSONAL CARE SERVICES - ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance 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 (AABD)." (3-19-07)

02. 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: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

b. 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; (3-19-07)

c. The RMS reviews the documentation for medical necessity; and (1-1-07)T

d. The participant has a plan of care. (1-1-07)T

03. State Plan Option. A participant who receives medical assistance 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. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

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 (AABD)." 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. (1-1-07)T

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

303. PERSONAL CARE SERVICES (PCS) - COVERAGE AND LIMITATIONS.

01. Medical Care and Services. 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:
(3-19-07)

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
(3-19-07)

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;
(3-19-07)

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;
(3-19-07)

d. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need;
(3-19-07)

e. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant;
(3-19-07)

f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met:
(3-19-07)

i. The task is not complex and can be safely performed in the given participant care situation;
(3-19-07)

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;
(3-19-07)

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;
(3-19-07)

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN;
(3-19-07)

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
(3-19-07)

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN.
(3-19-07)

02. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services:
(3-19-07)

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.
(3-19-07)

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (3-19-07)

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (3-19-07)

03. 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 or a Residential Care or Assisted Living Facility. The following living situations are specifically excluded as a personal residence: (3-19-07)

a. Certified nursing facilities or hospitals. (3-19-07)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (3-19-07)

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." (3-19-07)

04. Type of Service Limitations. The provider is excluded from delivering the following services: (3-19-07)

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-19-07)

b. Insertion or sterile irrigation of catheters; (3-19-07)

c. Injecting fluids into the veins, muscles or skin; and (3-19-07)

d. Administering medication. (3-19-07)

05. Participant Service Limitations. (3-19-07)

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (3-19-07)

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. (3-19-07)

06. Provider Coverage Limitations. (3-19-07)

a. The provider must not bill for more time than was actually spent in service delivery. (3-19-07)

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. (3-19-07)

304. PERSONAL CARE SERVICES - PROCEDURAL REQUIREMENTS.

01. 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. (3-19-07)

a. The plan of care for participants who live in their own homes is based on: (3-19-07)

i. The physician's or authorized provider's information if applicable; (1-1-07)T

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 (3-19-07)

iii. Information obtained from the participant. (3-19-07)

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. (3-19-07)

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. (3-19-07)

02. 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. (3-19-07)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

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. (3-19-07)

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: (3-19-07)

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; (3-19-07)

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; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

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. (3-19-07)

03. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes. (3-19-07)

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: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

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. (3-19-07)

c. A copy of the information required in Subsection 304.03 of these rules 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. (3-19-07)

d. 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 Subsection 304.03 of these rules. (3-19-07)

e. 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." (3-19-07)

f. 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." (3-19-07)

04. 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. (3-19-07)

305. PERSONAL CARE SERVICES - PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: (3-19-07)

a. Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed professional nurse; (3-19-07)

b. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (3-19-07)

c. 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. (3-19-07)

02. Provider Training Requirements. 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: (3-19-07)

a. Completed one (1) of the Department-approved developmental disabilities training courses; or (3-19-07)

b. Experience providing direct services to people with developmental disabilities. (3-19-07)

c. RMS determines whether developmental disability training is required. Providers who are qualified as QMRPs are exempted from the Department-approved developmental disabilities training course. (3-19-07)

d. 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: (3-19-07)

- i. The RMS verifies that there are no other qualified providers available; (3-19-07)
- 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 (3-19-07)
- iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (3-19-07)

03. Provider Exclusion. 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. (3-19-07)

04. Care Delivered in Provider's Home for a Child. 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. (3-19-07)

05. Care Delivered in Provider's Home for an Adult. 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." (3-19-07)

06. 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, "Criminal History and Background Checks." (3-19-07)

07. 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. (3-19-07)

306. PERSONAL ASSISTANCE AGENCY (PAA) - QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. (7-1-07)T

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-19-07)

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-19-07)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-19-07)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-19-07)

- d.** Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-19-07)
- e.** Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)
- f.** Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)
- g.** Billing Medicaid for services approved and authorized by the RMS; (3-19-07)
- h.** Collecting any participant contribution due; (7-1-07)T
- i.** Conducting, at least annually, participant satisfaction or quality control reviews which are available to the Department and the general public; and (7-1-07)T
- j.** Making referrals for PCS-eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified. (3-19-07)

307. PERSONAL CARE SERVICES - PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis according to Section 39-5606, Idaho Code. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and 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 1st of that year. (3-19-07)

04. Payment Levels for PAA. Medicaid will then establish payment levels for personal assistance agencies for personal assistance services as follows: (3-19-07)

a. 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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(3-19-07)

b. 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

(3-19-07)

- c. 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

(3-19-07)

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, 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 307.05.c of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

308. PERSONAL CARE SERVICES (PCS) - QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies are responsible for assuring that they provide quality services in compliance with applicable rules. (3-19-07)

02. Review Results. 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. (3-19-07)

03. Quality Improvement Plan. 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. (3-19-07)

309. -- 319. (RESERVED).

320. AGED OR DISABLED WAIVER SERVICES.

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 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.

(3-19-07)

321. AGED OR DISABLED WAIVER SERVICES - DEFINITIONS.

The following definitions apply to Sections 320 through 330 of these rules:

(3-19-07)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities.

(3-19-07)

02. Individual Service Plan. A document which outlines all services including, but not limited to, personal assistance services and instrumental activities of daily living (IADL), 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.

(3-19-07)

03. 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.

(3-19-07)

04. 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 agency.

(3-1-07)T

05. 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.

(3-19-07)

06. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program.

(3-19-07)

322. AGED OR DISABLED WAIVER SERVICES - ELIGIBILITY.

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:

(3-19-07)

01. Has a Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and

(3-19-07)

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and

(3-19-07)

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility.

(4-1-07)T

04. Functional Level for Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department. In determining need for nursing facility care an adult must require the level of assistance listed in Subsections 322.04 through 322.07 of this rule, according to the formula described in Subsection 322.08 of this rule.

(4-1-07)T

- 05. Critical Indicator - 12 Points Each.** (4-1-07)T
- a.** Total assistance with preparing or eating meals. (4-1-07)T
 - b.** Total or extensive assistance in toileting. (4-1-07)T
 - c.** Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (4-1-07)T
- 06. High Indicator - 6 Points Each.** (4-1-07)T
- a.** Extensive assistance with preparing or eating meals. (4-1-07)T
 - b.** Total or extensive assistance with routine medications. (4-1-07)T
 - c.** Total, extensive or moderate assistance with transferring. (4-1-07)T
 - d.** Total or extensive assistance with mobility. (4-1-07)T
 - e.** Total or extensive assistance with personal hygiene. (4-1-07)T
 - f.** Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (4-1-07)T
- 07. Medium Indicator - 3 Points Each.** (4-1-07)T
- a.** Moderate assistance with personal hygiene. (4-1-07)T
 - b.** Moderate assistance with preparing or eating meals. (4-1-07)T
 - c.** Moderate assistance with mobility. (4-1-07)T
 - d.** Moderate assistance with medications. (4-1-07)T
 - e.** Moderate assistance with toileting. (4-1-07)T
 - f.** Total, extensive, or moderate assistance with dressing. (4-1-07)T
 - g.** Total, extensive or moderate assistance with bathing. (4-1-07)T
 - h.** Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (4-1-07)T
- 08. Nursing Facility Level of Care, Adults.** In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (4-1-07)T
- a.** One (1) or more critical indicators = Twelve (12) points. (4-1-07)T
 - b.** Two (2) or more high indicators = Twelve (12) points. (4-1-07)T
 - c.** One (1) high and two (2) medium indicators = Twelve (12) points. (4-1-07)T
 - d.** Four (4) or more medium indicators = Twelve (12) points. (4-1-07)T

323. AGED OR DISABLED WAIVER SERVICES - PARTICIPANT ELIGIBILITY DETERMINATION. Waiver eligibility will be determined by the RMS. 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. (3-19-07)

01. Requirements for Determining Participant Eligibility. The RMS must determine that: (3-19-07)

a. The participant would qualify for nursing facility level of care under Sections 222 and 223 of these rules, if the waiver services listed in Section 326 of these rules were not made available; and (3-19-07)

b. 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 the RMS. 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. (3-19-07)

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 nursing facility care. (3-19-07)

d. Following the approval by the RMS 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. (3-19-07)

02. Admission to a Nursing Facility. A participant who is determined by the RMS to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility. (3-19-07)

03. Redetermination Process. Case Redetermination will be conducted by the RMS or its contractor. The redetermination process will verify that the participant continues to meet nursing facility level of care and the participant's continued need for waiver services. (3-19-07)

324. AGED OR DISABLED WAIVER SERVICES - TARGET GROUP.

Persons who would be Medicaid eligible if residing in a nursing facility, require the level of care provided in a nursing facility, 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. (3-19-07)

325. HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER - PARTICIPANT LIMITATIONS.

The number of Medicaid participants to receive waiver services under the Home and Community Based Services (HCBS) 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 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. (3-19-07)

326. AGED OR DISABLED WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

b. Assistance with activities of daily living; (3-19-07)

c. Meals, including special diets; (3-19-07)

- d.** Housekeeping; (3-19-07)
- e.** Laundry; (3-19-07)
- f.** Transportation; (3-19-07)
- g.** Opportunities for socialization; (3-19-07)
- h.** Recreation; and (3-19-07)
- i.** Assistance with personal finances. (3-19-07)
- j.** Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. (3-30-07)

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-19-07)

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

- a.** Intermittent Assistance may include the following. (3-19-07)
 - i.** Yard maintenance; (3-19-07)

- ii. Minor home repair; (3-19-07)
- iii. Heavy housework; (3-19-07)
- iv. Sidewalk maintenance; and (3-19-07)
- v. Trash removal to assist the participant to remain in their home. (3-19-07)
- b.** Chore activities may include the following: (3-19-07)
 - i. Washing windows; (3-19-07)
 - ii. Moving heavy furniture; (3-19-07)
 - iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)
 - iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)
 - v. Tacking down loose rugs and flooring. (3-19-07)
- c.** These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)
- d.** In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)
- 07. Adult Companion.** In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)
- 08. Consultation.** Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)
- 09. Home Delivered Meals.** Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)
 - a.** Rent or own their own home; (3-19-07)
 - b.** Are alone for significant parts of the day; (3-19-07)
 - c.** Have no regular caretaker for extended periods of time; and (3-19-07)
 - d.** Are unable to prepare a balanced meal. (3-19-07)
- 10. Homemaker Services.** Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-19-07)
- 11. Home Modifications.** Minor housing adaptations that are necessary to enable the participant to

function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caretaker for extended periods of time; and (3-19-07)

d. Would otherwise require extensive routine supervision. (3-19-07)

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

15. Service Coordination. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (3-19-07)

a. All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (3-19-07)

b. The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (3-19-07)

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (3-19-07)

- a.** The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)
- b.** The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)
- c.** Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)
- d.** Injections; (3-19-07)
- e.** Blood glucose monitoring; and (3-19-07)
- f.** Blood pressure monitoring. (3-19-07)

17. Habilitation. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, 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. (3-30-07)

18. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-30-07)

b. Federal Financial Participation (FFP) can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-30-07)

19. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (3-30-07)

327. AGED OR DISABLED WAIVER SERVICES - PLACE OF SERVICE DELIVERY.

01. Place of Service Delivery. Waiver services may be provided in the participant's: (3-19-07)

a. Personal residence; (3-19-07)

b. Employment program; or (3-19-07)

c. Community. (3-19-07)

02. Excluded Living Situations. Living situations specifically excluded as a personal residence are: (3-19-07)

a. Skilled, or Intermediate Care Facilities; (3-19-07)

b. Nursing Facility; (3-19-07)

c. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (3-19-07)

d. Hospitals. (3-19-07)

328. AGED OR DISABLED WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Role of the Regional Medicaid Services. The RMS will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by RMS staff or a contractor. The RMS will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (3-30-07)

a. Services which are not in the individual service plan approved by the RMS are not eligible for Medicaid payment. (3-19-07)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the RMS for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (3-19-07)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the RMS or its contractor. (3-19-07)

04. Individual Service Plan. All waiver services must be authorized by the RMS in the Region where the participant will be residing and services provided based on a written individual service plan. (3-30-07)

a. The initial individual service plan is developed by the RMS or its contractor, based on the UAI, in conjunction with: (3-19-07)

i. The waiver participant (with efforts made by the RMS to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); (3-30-07)

ii. The guardian, when appropriate; (3-30-07)

iii. The supervising nurse or case manager, when appropriate; and (3-19-07)

iv. Others identified by the waiver participant. (3-19-07)

b. The individual service plan must include the following: (3-19-07)

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)

iii. The providers of waiver services when known; (3-30-07)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)

v. The signature of the participant or his legal representative, agreeing to the plan. (3-19-07)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)

d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the RMS prior to the payment of services. (3-19-07)

e. The individual service plan, which includes all waiver services, is monitored by the Personal

Assistance Agency, participant, family, and the RMS or its contractor. (3-19-07)

05. Service Delivered Following a Written Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

- a.** The plan of care is developed by the plan of care team which includes: (3-30-07)
 - i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (3-30-07)
 - ii. The Department's administrative case manager; (3-30-07)
 - iii. The guardian when appropriate; (3-30-07)
 - iv. Service provider identified by the participant or guardian; and (3-30-07)
 - v. May include others identified by the waiver participant. (3-30-07)
- b.** The plan of care must be based on an assessment process approved by the Department. (3-30-07)
- c.** The plan of care must include the following: (3-30-07)
 - i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)
 - ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)
 - iii. The providers of waiver services; (3-30-07)
 - iv. Goals to be addressed within the plan year; (3-30-07)
 - v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)
 - vi. The signature of the participant or his legal representative. (3-30-07)
- d.** 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. (3-30-07)
- e.** The Department's case manager monitors the plan of care and all waiver services. (3-30-07)
- f.** The plan of care 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 care is subject to prior authorization by the Department. (3-30-07)

06. Provider Records. Records will be maintained on each waiver participant. (3-19-07)

- a.** Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)
 - i. Date and time of visit; (3-19-07)
 - ii. Services provided during the visit; (3-19-07)
 - iii. 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 (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMS 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. (3-19-07)

b. 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 RMS. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (3-19-07)

c. The individual service plan initiated by the RMS or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a of these rules and a copy of the most current individual service 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 individual service plan and UAI will be available from the RMS to each individual service provider with a release of information signed by the participant or legal representative. (3-19-07)

07. Provider Responsibility for Notification. The service provider is responsible to notify the RMS, 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. (3-19-07)

08. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

09. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (7-1-07)T

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (7-1-07)T

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (7-1-07)T

h. To maintain liability insurance coverage; (7-1-07)T

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (7-1-07)T

j. To make referrals for service coordination for a PCS-eligible participant when a need for such services is identified; and (7-1-07)T

k. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (7-1-07)T

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," including: (1-1-07)T

i. Companion services; (1-1-07)T

ii. Chore services; and (1-1-07)T

iii. Respite care services. (1-1-07)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (1-1-07)T

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules.

(3-19-07)

08. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers.

(3-19-07)

09. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho."

(1-1-07)T

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of:

(3-19-07)

a. Supervising the direct service;

(3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

(3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food;

(3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and

(3-19-07)

e. Being inspected and licensed as a food establishment by the district health department.

(3-19-07)

11. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards.

(3-19-07)

12. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner.

(3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served.

(3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served.

(3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks History and Background Checks."

(1-1-07)T

13. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need.

(3-19-07)

14. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications.

(3-19-07)

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

17. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-19-07)

18. Residential Habilitation Provider Qualifications. Residential habilitation services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a residential habilitation agency. The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-30-07)

- a.** Direct service staff must meet the following minimum qualifications: (3-30-07)
 - i.** Be at least eighteen (18) years of age; (3-30-07)
 - ii.** Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)
 - iii.** Have current CPR and First Aid certifications; (3-30-07)
 - iv.** Be free from communicable diseases; (3-30-07)
 - v.** Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)
 - vi.** Residential habilitation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (1-1-07)T
 - vii.** Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a program coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (3-30-07)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

- i.** Purpose and philosophy of services; (3-30-07)

- ii. Service rules; (3-30-07)
 - iii. Policies and procedures; (3-30-07)
 - iv. Proper conduct in relating to waiver participants; (3-30-07)
 - v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)
 - vi. Participant rights; (3-30-07)
 - vii. Methods of supervising participants; (3-30-07)
 - viii. Working with individuals with traumatic brain injuries; and (3-30-07)
 - ix. Training specific to the needs of the participant. (3-30-07)
- e.** Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-30-07)
- i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)
 - ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)
 - iii. Feeding; (3-30-07)
 - iv. Communication; (3-30-07)
 - v. Mobility; (3-30-07)
 - vi. Activities of daily living; (3-30-07)
 - vii. Body mechanics and lifting techniques; (3-30-07)
 - viii. Housekeeping techniques; and (3-30-07)
 - ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)
- f.** The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)
- g.** When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-30-07)

19. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

20. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. Supported employment service

providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

21. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

330. AGED OR DISABLED WAIVER SERVICES - PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

331. -- 449. (RESERVED).

SUB AREA: HOSPICE

(Sections 450 Through 459)

450. HOSPICE.

Medical assistance will provide payment for hospice services for eligible participants. Reimbursement will be based on Medicare program coverage as set out in Sections 450 through 456 of these rules. (3-19-07)

451. HOSPICE - DEFINITIONS.

The following definitions apply to Sections 450 through 456 of these rules. (3-19-07)

- 01. Attending Physician.** A physician who: (3-19-07)
- a.** Is a doctor of medicine or osteopathy; and (3-19-07)
- b.** Is identified by the participant, at the time he elects to receive hospice care, as having the most significant role in the determination and delivery of the participant's medical care. (3-19-07)
- 02. Benefit Period.** A period of time that begins on the first day of the month the participant elects hospice and ends on the last day of the eleventh successive calendar month. (3-19-07)
- 03. Bereavement Counseling.** Counseling services provided to the participant's family after the participant's death. (3-19-07)
- 04. Cap Amount.** The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid participants per Subsection 456.04 of these rules. (3-19-07)
- 05. 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 456.04 of these rules. (3-19-07)
- 06. Election Period.** One (1) of eight (8) periods within the benefit period which an participant may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. (3-19-07)
- 07. 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 that is appropriately trained and assigned to the hospice unit. Employee also refers to a volunteer under the jurisdiction of the hospice. (3-19-07)
- 08. Freestanding Hospice.** A hospice that is not part of any other type of participating provider. (3-19-07)
- 09. Hospice.** A public agency or private organization or a subdivision that: (3-19-07)
- a.** Is primarily engaged in providing care to terminally ill participants; and (3-19-07)
- b.** Meets the conditions specified for certification for participation in the Medicare and Medicaid programs and has a valid provider agreement. (3-19-07)
- 10. Independent Physician.** An attending physician who is not an employee of the hospice. (3-19-07)
- 11. Representative.** A person who is, because of the participant'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 participant. (3-19-07)
- 12. 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. (3-19-07)
- 13. Terminally Ill.** When an participant has a certified medical prognosis that his or her life expectancy is six (6) months or less per Subsection 454.01 of these rules. (3-19-07)

452. HOSPICE - ELIGIBILITY.

Inherent in the Hospice program is that a participant 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 participant or their representative be fully informed by a hospice before the beginning of a participant's care about the reason and nature of hospice care. The following are the eligibility requirements for Hospice: (3-19-07)

- 01. Certification.** A certification that the participant is terminally ill must have been completed in

accordance with Section 454.01 of these rules. (3-19-07)

02. Medically Necessary. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. (3-19-07)

03. Election of Services. The participant must elect hospice care in accordance with Section 454.02 of these rules. (3-19-07)

453. HOSPICE - COVERAGE REQUIREMENTS AND LIMITATIONS.

The following services are required: (3-19-07)

01. Nursing Care. Nursing care provided by or under the supervision of a registered nurse. (3-19-07)

02. Medical Social Services. 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. (3-19-07)

03. Physician Services. Physician's services performed by a physician as defined in Subsection 451.01 of these rules. (3-19-07)

04. Counseling Services. Counseling services provided to the terminally ill participant and the family members or other persons caring for the participant at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the participant's family or other caregiver to provide care, and for the purpose of helping the participant and those caring for him to adjust to the participant's approaching death. (3-19-07)

05. Inpatient Care. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a nursing facility 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 participant's family or other persons caring for the participant at home. (3-19-07)

06. Medical Equipment and Supplies. 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 is under hospice care. Medical supplies include only those that are part of the written plan of care. (3-19-07)

07. Home Health Services. 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 participant to carry out the plan of care. (3-19-07)

08. Therapies. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. (3-19-07)

09. Core Services. 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. (3-19-07)

454. HOSPICE - PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain the certification that a participant is terminally

ill in accordance with the following procedures: (3-19-07)

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 participant's attending physician (if the participant has one). The certification must include the statement that the participant's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). In the event the participant'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 participant's medical status. (3-19-07)

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 participant's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (3-19-07)

c. The hospice must maintain the monthly certification statements for review. (3-19-07)

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 of Facility Standards. The designated hospice must also notify the Medicaid program when the designated attending physician of a participant in their care is not a hospice employee. (3-19-07)

02. Election Procedures. If an participant elects to receive hospice care, he 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. (3-19-07)

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 participant remains in the care of a designated hospice and does not revoke the election. (3-19-07)

b. A participant 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. (3-19-07)

i. The hospice days available did not exceed two hundred ten (210) days in the benefit period due to the loss of financial eligibility. (3-19-07)

ii. The participant or the legal representative did not change hospices excessively per Subsection 454.05 of these rules. (3-19-07)

iii. The participant or the legal representative did not revoke hospice election periods more than eight (8) times per Subsection 454.04 of these rules. (3-19-07)

c. An participant may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a participant cannot designate an effective date that is earlier than the date that the election is made. (3-19-07)

d. A participant must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exceptions: (3-19-07)

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the participant. (3-19-07)

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. (3-19-07)

iii. Physician services provided by the participant's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (3-19-07)

03. Election of Hospice. The election statement must include the following items of information: (3-19-07)

a. Identification of the particular hospice that will provide care to the participant. (3-19-07)

b. The participant's or representative's acknowledgment that he has been given a full understanding of hospice care. (3-19-07)

c. The participant's or representative's acknowledgment that he understands that all Medicaid services except those identified in Subsection 454.02.d of these rules, are waived by the election during the hospice benefit period. (3-19-07)

d. The effective date of the election. (3-19-07)

e. The signature of the participant or the representative and the date of that signature. (3-19-07)

04. Revocation of Hospice Election. A participant or representative may revoke the election of hospice care at any time. (3-19-07)

a. To revoke the election of hospice care, the participant must file a signed statement with the hospice that includes that the participant revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. (3-19-07)

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. (3-19-07)

05. Change of Hospice. A participant may at any time change their designated hospice during election periods for which he is eligible. (3-19-07)

a. A participant may change designated hospices no more than six (6) times during the hospice benefit period. (3-19-07)

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the participant must file during the monthly election period, with the hospice from which he has received care and with the newly designated hospice, a dated and signed statement that includes the following information: (3-19-07)

i. The name of the hospice from which the participant has received care; (3-19-07)

ii. The name of the hospice from which he plans to receive care; and (3-19-07)

iii. The effective date of the change in hospices. (3-19-07)

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. (3-19-07)

06. Plan of Care. A plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. (3-19-07)

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. (3-19-07)

b. 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. (3-19-07)

c. 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. (3-19-07)

455. HOSPICE - PROVIDER QUALIFICATIONS AND DUTIES.

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. (3-19-07)

456. HOSPICE - PROVIDER REIMBURSEMENT.

With the exception of payment for physician services under Section 458 of these rules, Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which a participant 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. A description of the payment for each level of care is described in Subsections 456.01 through 456.04 of these rules. (3-19-07)

01. 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. (3-19-07)

02. 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. (3-19-07)

03. Inpatient Respite Care. The hospice will be paid at the inpatient respite care rate for each day that the participant 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. (3-19-07)

04. 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 participant receives hospice general inpatient care except as described in Section 458 of these rules. (3-19-07)

a. 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. (3-19-07)

b. 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 participants. (3-19-07)

c. Obligation of continuing care. After the participant's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that participant's care until the patient expires or until the participant revokes the election of hospice care. (3-19-07)

457. HOSPICE - 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 1st of each year and ending October

31st 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 participants during the same period by the designated hospice or its contracted agent(s). (3-19-07)

01. 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: (3-19-07)

a. 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%). (3-19-07)

b. 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 457.01 of these rules then no adjustment is made. (3-19-07)

c. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Subsection 457.01 of these rules then the payment limitation will be determined by: (3-19-07)

i. 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. (3-19-07)

ii. Multiplying excess inpatient care days by the routine home care rate. (3-19-07)

iii. Adding the amounts calculated in Subsections 457.01.c.i. and 457.01.c.ii. of these rules. (3-19-07)

iv. Comparing the amount in Subsection 457.01.c.iii. of these rules with interim payments made to the hospice for inpatient care during the "cap period." (3-19-07)

02. The amount by which interim payments for inpatient care exceeds the amount calculated as in Subsection 456.01.c.iv. of these rules is due from the hospice. (3-19-07)

458. HOSPICE - 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 participant'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. (3-19-07)

01. Hospice Employed Physician Direct Patient Service. 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 Section 459 of these rules 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. (3-19-07)

02. Volunteer Physician Services. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: (3-19-07)

a. 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. (3-19-07)

b. 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 Section 459 of these rules 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. (3-19-07)

459. HOSPICE - CAP ON OVERALL REIMBURSEMENT.

Aggregate payments to each hospice will be limited during a hospice cap period per Subsection 451.05 of these rules. The total payments made for services furnished to Medicaid participants 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. (3-19-07)

01. Overall Cap. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. (3-19-07)

02. Total Payment for Services. Total payment made for services furnished to Medicaid participants during this period means all payments for services rendered during the cap year, regardless of when payment is actually made. (3-19-07)

03. Calculation of Cap Amount. The "cap amount" is calculated by multiplying the number of participants 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 459.07 of these rules. (3-19-07)

04. Computation and Application of Cap Amount. The computation and application of the "cap amount" is made by the Department after the end of the cap period. (3-19-07)

05. Report Number of Medicaid Participants. The hospice must report the number of Medicaid participants electing hospice care during the period to the Department. (3-19-07)

a. This must be done within thirty (30) days after the end of the cap period: and (3-19-07)

b. If the participant is transferred to a non-certified hospice no payment to the non-certified hospice will be made and the certified hospice may count a complete participant benefit period in their cap amount. (3-19-07)

06. Certified in Mid-Month. 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. (3-19-07)

07. 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 participant's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the participant during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. (3-19-07)

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. (3-19-07)

b. Each hospice's cap amount will be computed as follows: (3-19-07)

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." (3-19-07)

ii. The proportion determined in Subsection 456.05 of these rules for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the participant first elected hospice. (3-19-07)

c. The participant 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 participant during the current cap year. (3-19-07)

08. Additional Amount for Nursing Facility Residents. An additional per diem amount will be paid for “room and board” of hospice residents in a certified nursing facility receiving routine or continuous care services. In this context, the term “room and board” includes 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 Sections 457 and 459 of these rules. 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 participant was a resident of that facility. (3-19-07)

460. HOSPICE - POST-ELIGIBILITY TREATMENT OF INCOME.

Where a participant is determined eligible for medical assistance 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 Section 227 of these rules. (3-19-07)

461. -- 499. (RESERVED).

SUB PART: ENHANCED DEVELOPMENTAL DISABILITY SERVICES

(Sections 500 Through 719)

500. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS.

Prior to receiving developmental disability services as provided in Sections 507 through 719 of these rules, the participant must be determined to have a developmental disability. (3-19-07)

501. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS - ELIGIBILITY.

The definitions and standards in the table below must be used to determine whether a participant meets criteria as a person with a developmental disability under Section 66-402, Idaho Code.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	Standards
“Developmental Disability” means a chronic disability of a person which appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND
(a) is attributable to an impairment, such as mental retardation,	“Is attributable to an impairment” means that there is a causal relationship between the presence of an impairing condition and the developmental disability. Age 5 through Adult: There is a presumption that mental retardation exists when a full scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of 5 points.) Birth to Age 5: An IQ test score is not required below the age of 5. In these cases it may be necessary to rely on the results of a functional assessment. There is a presumption that mental retardation exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy,	Medical Diagnosis which requires documentation.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	Standards
epilepsy,	Medical Diagnosis which requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for 3 years.
autism,	Includes the diagnosis of pervasive developmental disorder.
or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services,	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) Mental Retardation: A full scale IQ score above 75 can in some circumstances be considered a related or similar condition to mental retardation when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to mental retardation. Cerebral Palsy: Conditions related or similar to cerebral palsy include disorders which cause a similar disruption in motor function. Epilepsy: Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments; and	AND
(b) results in substantial functional limitations in three (3) or more of the following major life activities;	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. Age 3 through Adult: A score of 2 standard deviations below the mean creates a presumption of a functional limitation. Birth to Age 3: The following criteria must be utilized to determine a substantial functional limitations for children under 3: a. The child scores 30% below age norm; or b. The child exhibits a 6 month delay; or c. The child scores 2 standard deviations below the mean.
self care,	Adult: A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair his ability to conduct other activities of daily living or retain employment. Birth to Age 21: A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	Standards
receptive and expressive language,	Age 3 through Adult: A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). Birth to Age 3: A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to 2 years) or demonstrates at least 2 standard deviations below the mean in either area or 1 1/2 below in both areas of language development.
learning,	Birth through Adult: A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self care, language, academic, or vocational skills.
mobility,	Adult: A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. Birth to Age 21: A substantial limitation would be measured by an age appropriate instrument which compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction,	Adult: A substantial functional limitation is manifest when a person requires assistance in managing his personal finances, protecting his self interest, or making decisions that may affect his well being. Birth to Age 21: A substantial limitation is manifest when the child is unable to help his self or cooperate with others age appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.
capacity for independent living, or	Adult: A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. Birth to Age 21: A substantial limitation would be measured by an age-appropriate instrument which compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	Standards
economic self-sufficiency; and	Adult: A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that his earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. Age 5 to Age 21: Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. Birth to Age 5: A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND
(c) reflects the needs 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.	Age 5 through Adult: Life-long or extended duration means the developmental disability is one which has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. Birth to Age 5: The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

(3-19-07)

502. (RESERVED).

503. DEVELOPMENTAL DISABILITY DETERMINATION - TEST INSTRUMENTS.

A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

01. Test Instruments For Adults. Unless contra-indicated, the following test instruments or subsequent revisions must be used to determine eligibility: (3-19-07)

a. Cognitive: Wechsler Adult Intelligence Scale-Third Edition (WAIS-III). (3-19-07)

b. Functional: Scales of Independent Behavior-Revised (SIB-R). (3-19-07)

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills, be racially and culturally non-discriminatory, and be conducted in settings that are typically comfortable and familiar to the child. Unless contraindicated, test instruments such as the following must be used with children: (3-19-07)

a. Cognitive: (3-19-07)

i. Bayley Scales of Infant Development, Third Edition (BSID-III) for ages birth through forty-two (42) months; (3-19-07)

- ii. Stanford Binet Intelligence Scales, Fifth Edition (SB5) for ages two (2) years through adult;
(3-19-07)
- iii. Wechsler Preschool and Primary Scale of Intelligence -Third Edition (WPPSI-III) for ages two (2) years, six (6) months to seven (7) years, three (3) months;
(3-19-07)
- iv. Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV) for ages six (6) through sixteen (16) years, eleven (11) months; or
(3-19-07)
- v. Wechsler Adult Intelligence Scale - Third Edition (WAIS-III) for ages sixteen (16) years to adult.
(3-19-07)
- b. Functional:** (3-19-07)
 - i. American Association on Mental Retardation Adaptive Behavior Scale: School (ABS-S) for ages three (3) through twenty-one (21) years;
(3-19-07)
 - ii. Battelle Developmental Inventory, 2nd Edition (BDI-2) for ages birth to ninety-five (95) months;
(3-19-07)
 - iii. Developmental Profile II (DP-II) for ages birth through twelve (12) years;
(3-19-07)
 - iv. Scales of Independent Behavior (SIB-R) for ages birth through adult;
(3-19-07)
 - v. Vineland Adaptive Behavior Scales (VABS) for ages birth to eighteen (18) years, eleven (11) months;
(3-19-07)
 - vi. Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years;
(3-19-07)
 - vii. Preschool Language Scale - 3 (PLS-3) for ages birth to three (3) years;
(3-19-07)
 - viii. Peabody Developmental Motor Scales for ages birth to three (3) years; or
(3-19-07)
 - ix. Receptive-Expressive Emergent Language Scale - Third Edition (REEL- 3) for ages birth to three (3) years.
(3-19-07)

504. -- 506. (RESERVED).

507. BEHAVIORAL HEALTH PRIOR AUTHORIZATION (PA).

The purpose of Behavioral Health Prior Authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service.
(3-19-07)

508. BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS - DEFINITIONS.

For the purposes of these rules the following terms are used as defined below.
(3-19-07)

- 01. Adult.** A person who is eighteen (18) years of age or older or an ISSH Waiver participant.
(3-19-07)
- 02. Assessment.** A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service.
(3-19-07)
- 03. Clinical Review.** A process of professional review that validates the need for continued services.
(3-19-07)

- 04. Community Crisis Support.** Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)
- 05. Concurrent Review.** A clinical review to determine the need for continued prior authorization of services. (3-19-07)
- 06. Exception Review.** A clinical review of a plan that falls outside the established standards. (3-19-07)
- 07. Interdisciplinary Team.** For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)
- 08. Level of Support.** An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)
- 09. Person-Centered Planning Process.** A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-19-07)
- 10. Person-Centered Planning Team.** The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)
- 11. Plan Developer.** A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)
- 12. Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)
- 13. Plan Monitor Summary.** A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns. (3-19-07)
- 14. Plan of Service.** An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)
- 15. Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)
- 16. Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)
- 17. Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)
- 18. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)
- 19. Right Price.** The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

21. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

22. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

23. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

24. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

25. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

509. BEHAVIORAL HEALTH PRIOR AUTHORIZATION - ELIGIBILITY DETERMINATION.

The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/MR level of care for waiver services in accordance with Section 584 of these rules. (3-19-07)

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

a. The assessment process must be completed; and (3-19-07)

b. The assessor must provide the results of the assessment to the participant. (3-19-07)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on 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 for use in this determination. (3-19-07)

04. ICF/MR Level of Care Determination for Waiver Services. The assessor will determine ICF/MR level of care for adults in accordance with Section 584 of these rules. (3-19-07)

510. (RESERVED).

511. INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY - COVERAGE AND LIMITATIONS. The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults:

(3-19-07)

01. DD/ISSH Waiver Services. DD/ISSH Waiver services as described in Sections 700 through 719 of these rules; and (3-19-07)

02. Developmental Disability Agency Services. Developmental Disability Agency services as described in Sections 650 through 660 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies"; and (3-19-07)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD 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: (3-19-07)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. (3-19-07)

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-19-07)

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07))

513. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PLAN OF SERVICE.

In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-19-07)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are

significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

- a.** Durable Medical Equipment (DME); (3-19-07)
- b.** Transportation; and (3-19-07)
- c.** Physical, speech and occupational therapy provided outside of a Development Disabilities Agency (DDA). (3-19-07)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (3-19-07)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

- a.** Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)
- b.** Contact with service providers to identify barriers to service provision; (3-19-07)
- c.** Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)
- d.** Review of provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (3-19-07)
- e.** Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-19-07)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

- a.** The status of supports and services to identify progress; (3-19-07)
- b.** Maintenance; or (3-19-07)
- c.** Delay or prevention of regression. (3-19-07)

07. Plan Monitor Summary. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review. (3-19-07)

08. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or

prevent regression. (3-19-07)

09. Negotiation for the Plan of Service. The plan of service must be individualized with the participant if the requested services fall outside the individualized 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. (3-19-07)

10. Informed Consent. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

11. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

12. 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. (3-19-07)

13. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER

evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

14. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-19-07)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

15. Reconsiderations, Complaints, and Administrative Appeals.

a. Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request. (3-19-07)

b. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid, Bureau of Care Management. (3-19-07)

c. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

514. BEHAVIORAL HEALTH PRIOR AUTHORIZATION - PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. (3-19-07)

01. Methodology for Developing Participant Budget Prior to October 1, 2006. The participant budget is developed using the following methodology: (3-19-07)

a. Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services; (3-19-07)

b. Review all assessment information identified in Section 512 of these rules; (3-19-07)

c. Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 514.01.c.). There are six (6) levels of support, each corresponding to a support score range.

TABLE 514.01.c. - LEVEL OF SUPPORT	
Support Score Range	Level of Support
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

(3-19-07)

d. Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (3-19-07)

02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs. (3-19-07)

03. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD and ISSH waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-19-07)

a. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect

information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology. (3-19-07)

b. 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 (3-19-07).

c. 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. (3-19-07)

04. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/MR with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

515. BEHAVIORAL HEALTH - QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. (3-19-07)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-19-07)

03. Exception Review. 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. (3-19-07)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (3-19-07)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

516. -- 579. (RESERVED).

580. INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR).

The Department will pay for services in an ICF/MR. ICFs/MR are intermediate care facilities whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with mental retardation or persons with related conditions. (3-19-07)

581. ICF/MR - ELIGIBILITY.

Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer (RNR) has determined that the individual meets the criteria for ICF/MR services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (3-19-07)

582. ICF/MR - DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.

Applications for Medicaid payment of an individual with mental retardation, or related condition, in an ICF/MR will be through the Department's RMS staff. All required information necessary for a medical entitlement determination must be submitted to the Regional Medicaid Services 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. (3-19-07)

583. ICF/MR - 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. (3-19-07)

- 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: (3-19-07)
- a.** Diagnosis (primary and secondary); (3-19-07)
 - b.** Medical findings and history; (3-19-07)
 - c.** Mental and physical functional capacity; (3-19-07)
 - d.** Prognosis; mobility status; and (3-19-07)
 - e.** A statement by the physician certifying the level of care needed as ICF/MR for a specific participant. (3-19-07)
- 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: (3-19-07)
- a.** Orders for medications and treatments; (3-19-07)
 - b.** Diet; and (3-19-07)
 - c.** Professional rehabilitative and restorative services and special procedures, where appropriate. (3-19-07)
- 03. Social Evaluation.** A social evaluation, current within ninety (90) days of admission, which includes: (3-19-07)
- a.** Condition at birth; (3-19-07)
 - b.** Age at onset of condition; (3-19-07)
 - c.** Summary of functional status, such as skills level, activities of daily living; and (3-19-07)
 - d.** Family social information. (3-19-07)
- 04. Psychological Evaluation.** A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, which includes: (3-19-07)
- a.** Diagnosis; (3-19-07)
 - 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; (3-19-07)
 - c.** Mental and physical functioning capacity; and (3-19-07)
 - d.** Recommendation concerning placement and primary need for active treatment. (3-19-07)
- 05. Initial Plan of Care by ICF/MR.** An initial plan of care developed by the admitting ICF/MR. (3-19-07)

584. ICF/MR - CRITERIA FOR DETERMINING ELIGIBILITY.

Individuals who have mental retardation or a related condition as defined in Section 66-402, Idaho Code and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an 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, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/MR level of care and be eligible for services provided in an ICF/MR. The following must be met in Subsections 584.01 through 584.08 of these rules. (3-19-07)

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 Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (3-19-07)

02. Active Treatment. Persons living in an ICF/MR, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain his functional level. (3-19-07)

a. 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. (3-19-07)

b. The following criteria/components will be utilized when evaluating the need for active treatment: (3-19-07)

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (3-19-07)

ii. 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. (3-19-07)

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, other than services in an institution for mental disease, in the near future. (3-19-07)

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. (3-19-07)

05. Functional Limitations. (3-19-07)

a. 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 (3-19-07)

b. 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 (3-19-07)

06. Maladaptive Behavior. (3-19-07)

a. 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 (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or (3-19-07)

b. 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 (3-19-07)

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/MR level of care if they display a combination of criteria as described in Subsections 585.05 and 585.06 of these rules 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: (3-19-07)

a. 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-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or (3-19-07)

b. 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-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or (3-19-07)

08. 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. (3-19-07)

09. Annual Redetermination for ICF/MR Level of Care for Community Services. The RMS 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 will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (3-19-07)

a. 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. (3-19-07)

b. 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. (3-19-07)

585. ICF/MR - COVERAGE REQUIREMENTS AND LIMITATIONS.

The minimum content of care and services for ICF/MR must include the services listed below and social and recreational activities. (3-19-07)

01. Care and Services Provided. (3-19-07)

a. The minimum content of care and services for ICF/MR participants must include the following: (3-19-07)

i. Room and board; and (3-19-07)

ii. Bed and bathroom linens; and (3-19-07)

iii. Nursing care, including special feeding if needed; and (3-19-07)

iv. Personal services; and (3-19-07)

v. Supervision as required by the nature of the participant's illness; and (3-19-07)

vi. Special diets as prescribed by a participant's physician; and (3-19-07)

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 (3-19-07)

viii. Dressings; and (3-19-07)

ix. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and (3-19-07)

x. Application or administration of all drugs; and (3-19-07)

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 disposable gloves; and (3-19-07)

xii. Social and recreational activities; and (3-19-07)

xiii. Items which are utilized by individual participants but which are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (3-19-07)

02. Wheelchairs. 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 participant cost effectively. (3-19-07)

586. ICF/MR - PROCEDURAL RESPONSIBILITIES.

Each long term care facility administrator, or his authorized representative, must report to the appropriate Field Office within three (3) working days of the date the facility has knowledge of the following. (3-19-07)

01. Readmissions or Discharges. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (3-19-07)

02. Changes to Participant's Income. Any changes in the amount of a participant's income. (3-19-07)

03. Participant's Account Exceeds Limitations. When a participant's account has exceed the following amount; (3-19-07)

a. For a single individual, one thousand eight hundred dollars (\$1,800);or (3-19-07)

b. For a married couple, two thousand eight hundred dollars (\$2,800). (3-19-07)

04. Other Financial Information for Participant. Other information about a participant's finances which may potentially affect eligibility for medical assistance. (3-19-07)

05. 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. (3-19-07)

a. 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 participants. For audit purposes, such financial losses are not reimbursable as a reasonable cost of participant care. Such losses cannot be made the financial responsibility of the Department's participant. (3-19-07)

b. Persons living in an ICF/MR will be transitioned to a less restrictive environment within thirty (30) days of the determination that the participant does not meet ICF/MR level of care. (3-19-07)

06. 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 ICF/MR care, the tentative decision is: (3-19-07)

- a. Discussed with the facility administrator or the director of nursing services; (3-19-07)
- b. The resident's physician is notified of the tentative decision; (3-19-07)
- c. The case is submitted to the Regional Review Committee for a final decision; and (3-19-07)
- d. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the participant by the Eligibility Examiner. (3-19-07)

07. Appeal of Determinations. The resident or his representative may appeal the decisions under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

08. Supplemental On-Site Visit. The Regional Nurse Reviewer may conduct utilization control supplemental on-site visits in an ICF/MR when indicated. Some indications may be: (3-19-07)

- a. Follow-up activities; (3-19-07)
- b. A verification of a participant's appropriateness of placement or services; and (3-19-07)
- c. Conduct complaint investigations at the Department's request. (3-19-07)

09. Determination of Entitlement to Long-Term Care. Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer has determined that the individual meets the criteria for ICF/MR care and services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (3-19-07)

a. The criteria for determining a Participant's need for intermediate care for the mentally retarded is described in Sections 583 and 584 of these rules. In addition, the IOC/UC nurse must determine whether a Participant's needs could be met by non-participant inpatient alternatives including, but not limited to, remaining in an independent living arrangement or residing in a room and board situation. (3-19-07)

b. The participant can select any certified facility to provide the care required. (3-19-07)

c. The final decision as to the level of care required by a Participant must be made by the IOC/UC Nurse. (3-19-07)

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. (3-19-07)

e. No payment must be made by the Department on behalf of any eligible Participant to any long-term care facility which, in the judgment of the Inspection Of Care/Utilization Control Team is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (3-19-07)

10. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. (3-19-07)

587. ICF/MR - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as an ICF/MR facility. (3-19-07)

02. Licensure and Certification. (3-19-07)

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 participants. (3-19-07)

b. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for ICF/MR, the Department must certify to the appropriate branch of government that the facility meets the standards for ICF/MR types of care. (3-19-07)

c. 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. (3-19-07)

d. 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. (3-19-07)

03. 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 participants 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. (3-19-07)

04. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to a participant in an ICF/MR setting will be dependent upon the level of involvement and the need for services and supports of the participant as determined by the Department. Level of involvement relates to the severity of a participant's mental retardation. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. Staffing levels will be subject to the following constraints: (3-19-07)

a. Direct care staffing for a severely and profoundly retarded participant residing in an ICF/MR must be a maximum of sixty-eight point twenty five (68.25) hours per week. (3-19-07)

b. Direct care staffing for a moderately retarded participant residing in an ICF/MR must be limited to a maximum of fifty-four point six (54.6) hours per week. (3-19-07)

c. Direct care staffing for a mildly retarded participant residing in an ICF/MR must be limited to a maximum of thirty four point one two five (34.125) hours per week. (3-19-07)

05. Direct Care Staff Hours. 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 587.04 of these rules. (3-19-07)

06. Phase-In Period. If enactment of Subsection 587.04 of these rules 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. (3-19-07)

07. 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 participants, 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. (3-19-07)

588. ICF/MR - PROVIDER REIMBURSEMENT.

01. Payment Methodology. ICF/MR facilities will be reimbursed in accordance with the methodology listed in Sections 588 through 633 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of ICF/MR care is to include the date of the participant's discharge only if the discharge occurred after 3 p.m. and is not discharged to a related provider. If a Medicaid patient dies in an ICF/MR, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. (3-19-07)

589. ICF/MR - REASONABLE COST PRINCIPLES.

To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (3-19-07)

01. Application of Reasonable Cost Principles. (3-19-07)

a. Reasonable costs of any services are determined in accordance with rules found in the Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (3-19-07)

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (3-19-07)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (3-19-07)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Chapter 1, Idaho Code, or are unallowable by application of promulgated regulation. (3-19-07)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (3-19-07)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (3-19-07)

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (3-19-07)

03. Costs Not Related to Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (3-19-07)

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply

with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property. If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (3-19-07)

590. ICF/MR - ALLOWABLE COSTS.

The following definitions and explanations apply to allowable costs: (3-19-07)

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. (3-19-07)

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (3-19-07)

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable as provided in PRM, Section 300. (3-19-07)

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (3-19-07)

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 597 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (3-19-07)

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (3-19-07)

b. Supplies and services provided for the owner's personal use. (3-19-07)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (3-19-07)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (3-19-07)

e. Keyman life insurance. (3-19-07)

f. Living expenses, including those paid for related persons. (3-19-07)

06. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (3-19-07)

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 630 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (3-19-07)

- 08. Dues, Licenses and Subscriptions.** Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (3-19-07)
- 09. Employee Benefits.** Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (3-19-07)
- 10. Employee Recruitment.** Costs of advertising for new employees, including applicable entertainment costs, are allowable. (3-19-07)
- 11. Entertainment Costs Related to Patient Care.** Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (3-19-07)
- 12. Food.** Costs of raw food, not including vending machine items, are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (3-19-07)
- 13. Home Office Costs.** Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (3-19-07)
- 14. Insurance.** Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (3-19-07)
- 15. Interest.** Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (3-19-07)
- 16. Lease or Rental Payments.** Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services will not be reported as property costs and will be allowable based on reasonable cost principles subject to other limitations contained herein. (3-19-07)
- 17. Malpractice or Public Liability Insurance.** Premiums for malpractice and public liability insurance must be reported as administrative costs. (3-19-07)
- 18. Payroll Taxes.** The employer's portion of payroll taxes is reimbursable. (3-19-07)
- 19. Property Costs.** Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For ICFs/MR, the property rental rate is paid as described in Section 630 of these rules. (3-19-07)
- a.** Amortization of leasehold improvements will be included in property costs. (3-19-07)
 - i** Straight line depreciation on fixed assets is included in property costs. (3-19-07)
 - ii.** Depreciation of moveable equipment is an allowable property cost. (3-19-07)
 - b.** Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (3-19-07)
- 20. Property Insurance.** Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting

purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (3-19-07)

21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (3-19-07)

22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (3-19-07)

23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable. (3-19-07)

24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (3-19-07)

591. ICF/MR - NONALLOWABLE COSTS.

The following definitions and explanations apply to nonallowable costs: (3-19-07)

01. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (3-19-07)

02. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (3-19-07)

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (3-19-07)

04. Charity Allowances. Cost of free care or discounted services are nonallowable. (3-19-07)

05. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other sections of this chapter, such as Section 589 or 595 of these rules, when applicable. (3-19-07)

06. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1. (3-19-07)

07. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (3-19-07)

08. Goodwill. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (3-19-07)

09. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (3-19-07)

10. Interest. Interest to finance nonallowable costs are nonallowable. (3-19-07)

11. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (3-19-07)

12. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable. (3-19-07)

13. **Organization.** Organization costs are nonallowable, see PRM, Section 2134. (3-19-07)
14. **Pharmacist Salaries.** Salaries and wages of pharmacists are nonallowable. (3-19-07)
15. **Prescription Drugs.** Prescription drug costs are nonallowable. (3-19-07)
16. **Related Party Interest.** Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2. (3-19-07)
17. **Related Party Nonallowable Costs.** All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (3-19-07)
18. **Related Party Refunds.** All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (3-19-07)
19. **Self-Employment Taxes.** Self-employment taxes, as defined by the Internal Revenue Service, which apply to facility owners are nonallowable. (3-19-07)
20. **Telephone Book Advertising.** Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (3-19-07)
21. **Vending Machines.** Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (3-19-07)
- 592. ICF/MR - HOME OFFICE COST PRINCIPLES.**
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (3-19-07)
- 593. ICF/MR - RELATED PARTY TRANSACTIONS.**
01. **Principle.** Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (3-19-07)
02. **Cost Allowability - Regulation.** Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (3-19-07)
- 594. ICF/MR - APPLICATION OF RELATED PARTY TRANSACTIONS.**
01. **Determination of Common Ownership or Control in the Provider Organization and Supply Organization.** In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (3-19-07)
- a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (3-19-07)
- b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. (3-19-07)
02. **Cost to Related Organizations.** The charges to the provider from related organizations may not

exceed the billing to the related organization for these services. (3-19-07)

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. (3-19-07)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. (3-19-07)

595. ICF/MR - COMPENSATION OF RELATED PERSONS.

Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (3-19-07)

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (3-19-07)

a. Where such persons perform services without pay, no cost may be imputed. (3-19-07)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (3-19-07)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (3-19-07)

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (3-19-07)

a. Husband or wife; (3-19-07)

b. Son or daughter or a descendent of either; (3-19-07)

c. Brother, sister, stepbrother, stepsister or descendent thereof; (3-19-07)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (3-19-07)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (3-19-07)

f. A descendent of a brother or sister of the provider's father or mother; (3-19-07)

g. Any other person with whom the provider does not have an arms length relationship. (3-19-07)

596. ICF/MR - INTEREST EXPENSE.

Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (3-19-07)

597. ICF/MR - IDAHO OWNER-ADMINISTRATIVE COMPENSATION.

Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. (3-19-07)

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951

Licensed Bed Range	Upper limit
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

(3-19-07)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (3-19-07)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 597.01. of these rules. Allowable compensation will be determined as follows: (3-19-07)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. (3-19-07)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (3-19-07)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 597.01 of these rules. (3-19-07)

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (3-19-07)

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (3-19-07)

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (3-19-07)

598. -- 599. (RESERVED).

600. ICF/MR - OCCUPANCY ADJUSTMENT FACTOR.

In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (3-19-07)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (3-19-07)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (3-19-07)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (3-19-07)

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (3-19-07)

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (3-19-07)

601. ICF/MR - RECAPTURE OF DEPRECIATION.

Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (3-19-07)

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (3-19-07)

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (3-19-07)

602. ICF/MR - REPORTING SYSTEM.

The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (3-19-07)

01. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs. (3-19-07)

02. Disclosure. Adequate financial disclosure. (3-19-07)

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (3-19-07)

04. Criteria. Criteria for evaluating policies and procedures. (3-19-07)

603. ICF/MR - REPORTING SYSTEM PRINCIPLE AND APPLICATION.

The provider will be required to file mandatory annual cost reports. (3-19-07)

01. Cost Report Requirements. The fiscal year end cost report filing must include: (3-19-07)

a. Annual income statement (two (2) copies); (3-19-07)

b. Balance sheet; (3-19-07)

c. Statement of ownership; (3-19-07)

d. Schedule of patient days; (3-19-07)

e. Schedule of private patient charges; (3-19-07)

f. Statement of additional charges to residents over and above usual monthly rate; and (3-19-07)

g. Other schedules, statements, and documents as requested. (3-19-07)

02. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (3-19-07)

03. Criteria of Reports. All reports must meet the following criteria: (3-19-07)

a. State approved formats must be used. (3-19-07)

b. Presented on accrual basis. (3-19-07)

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (3-19-07)

d. Appropriate detail must be provided on supporting schedules or as requested. (3-19-07)

04. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (3-19-07)

05. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (3-19-07)

06. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements will be met: (3-19-07)

a. Outgoing management or administration will file an adjusted-period cost report if it is necessary. This report will meet the criteria for annual cost reports, except that it will be filed not later than sixty (60) days after the change in management or ownership. (3-19-07)

b. The Department may require an appraisal at the time of a change in ownership. (3-19-07)

07. Reporting Period. When required for establishing rates, new ICF/MR providers will be required to submit cost projections for the first year of operations. Thereafter, the normal reporting period coincides with the provider's standard fiscal year. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. (3-19-07)

604. (RESERVED).

605. ICF/MR - FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (3-19-07)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (3-19-07)

606. ICF/MR - FAILURE TO FILE.

Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (3-19-07)

607. ICF/MR - ACCOUNTING SYSTEM.

Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (3-19-07)

608. -- 609. (RESERVED).

610. ICF/MR - AUDITS.

All financial reports are subject to audit by Departmental representatives. (3-19-07)

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (3-19-07)

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (3-19-07)

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (3-19-07)

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (3-19-07)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (3-19-07)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (3-19-07)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. (3-19-07)

08. Final Settlement. To effect final settlement when required by Sections 587 through 632 of these rules. (3-19-07)

611. ICF/MR - AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year.

(3-19-07)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (3-19-07)

03. Additional Audits. In addition, audits may be required where: (3-19-07)

a. A significant change of ownership occurs. (3-19-07)

b. A change of management occurs. (3-19-07)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (3-19-07)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (3-19-07)

612. ICF/MR - AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (3-19-07)

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3 states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (3-19-07)

03. Examination of Records. Examination of records and documents may include: (3-19-07)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (3-19-07)

b. Minutes and memos of the governing body including committees and its agents. (3-19-07)

c. All contracts. (3-19-07)

d. Tax returns and records, including workpapers and other supporting documentation. (3-19-07)

e. All insurance contracts and policies including riders and attachments. (3-19-07)

f. Leases. (3-19-07)

g. Fixed asset records (see audit section - Capitalization of Assets). (3-19-07)

h. Schedules of patient charges. (3-19-07)

i. Notes, bonds and other evidences of liability. (3-19-07)

j. Capital expenditure records. (3-19-07)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (3-19-07)

l. Evidence of litigations the facility and its owners are involved in. (3-19-07)

m. Documents of ownership including attachments which describe the property. (3-19-07)

- n.** All invoices, statements and claims. (3-19-07)
- o.** Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, paragraph 2404.4(Q). (3-19-07)
- p.** Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (3-19-07)
- q.** All patient records, including trust funds and property. (3-19-07)
- r.** Time studies and other cost determining information. (3-19-07)
- s.** All other sources of information needed to form an audit opinion. (3-19-07)
- 04. Adequate Documentation.** (3-19-07)
- a.** Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to participants. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation which pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. (3-19-07)
- b.** Adequate expenses documentation including an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (3-19-07)

 - i. Date of service or sale; (3-19-07)
 - ii. Terms and discounts; (3-19-07)
 - iii. Quantity; (3-19-07)
 - iv. Price; (3-19-07)
 - v. Vendor name and address; (3-19-07)
 - vi. Delivery address if applicable; (3-19-07)
 - vii. Contract or agreement references; and (3-19-07)
 - viii. Description, including quantity, sizes, specifications brand name, services performed. (3-19-07)
- c.** Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (3-19-07)
- d.** Completed depreciation records must meet the following criteria for each asset: (3-19-07)

 - i. Description of the asset including serial number, make, model, accessories, and location. (3-19-07)
 - ii. Cost basis should be supported by invoices for purchase, installation, etc. (3-19-07)
 - iii. Estimated useful life. (3-19-07)
 - iv. Depreciation method such as straight line, double declining balance, etc. (3-19-07)

- v. Salvage value. (3-19-07)
- vi. Method of recording depreciation on a basis consistent with accounting policies. (3-19-07)
- vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (3-19-07)
- viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (3-19-07)
- e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (3-19-07)
- f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 2004 revised edition. Guidelines Lives, which is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)
- g. Lease purchase agreements may generally be recognized by the following characteristics: (3-19-07)
 - i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (3-19-07)
 - ii. Intent to create security interest; (3-19-07)
 - iii. Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (3-19-07)
 - iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (3-19-07)
 - v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (3-19-07)
- h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (3-19-07)
 - i. Complete personnel records containing the following: (3-19-07)
 - i. Application for employment. (3-19-07)
 - ii. W-4 Form. (3-19-07)
 - iii. Authorization for other deductions such as insurance, credit union, etc. (3-19-07)
 - iv. Routine evaluations. (3-19-07)
 - v. Pay raise authorization. (3-19-07)
 - vi. Statement of understanding of policies, procedures, etc. (3-19-07)
 - vii. Fidelity bond application (where applicable). (3-19-07)
- 05. Internal Control.** (3-19-07)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (3-19-07)

- i. Safeguarding assets and resources against waste, fraud, and inefficiency. (3-19-07)
- ii. Promoting accuracy and reliability in financial records. (3-19-07)
- iii. Encouraging and measuring compliance with company policy and legal requirements. (3-19-07)
- iv. Determining the degree of efficiency related to various aspects of operations. (3-19-07)

b. An adequate system of internal control over cash disbursements would normally include: (3-19-07)

- i. Payment on invoices only, or statements supported by invoices. (3-19-07)
- ii. Authorization for purchase such as a purchase order. (3-19-07)
- iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (3-19-07)
- iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (3-19-07)
- v. Check of invoice accuracy. (3-19-07)
- vi. Approval policy for invoices. (3-19-07)
- vii. Method of invoice cancellation to prevent duplicating payment. (3-19-07)
- viii. Adequate separation of duties between ordering, recording, and paying. (3-19-07)
- ix. System separation of duties between ordering, recording, and paying. (3-19-07)
- x. Signature policy. (3-19-07)
- xi. Pre-numbered checks. (3-19-07)
- xii. Statement of policy regarding cash or check expenditures. (3-19-07)
- xiii. Adequate internal control over the recording of transactions in the books of record. (3-19-07)
- xiv. An imprest system for petty cash. (3-19-07)

06. Accounting Practices. Sound accounting practices normally include the following: (3-19-07)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (3-19-07)

b. Chart of accounts. (3-19-07)

c. A budget or operating plan. (3-19-07)

613. ICF/MR - PATIENT FUNDS.

The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (3-19-07)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's

discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (3-19-07)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (3-19-07)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (3-19-07)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (3-19-07)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (3-19-07)

03. Fund Management. Proper management of such funds would include the following as minimum: (3-19-07)

a. Savings accounts, maintained separately from facility funds. (3-19-07)

b. An accurate system of supporting receipts and disbursements to patients. (3-19-07)

c. Written authorization for all deductions. (3-19-07)

d. Signature verification. (3-19-07)

e. Deposit of all receipts of the same day as received. (3-19-07)

f. Minimal funds kept in the facility. (3-19-07)

g. As a minimum these funds must be kept locked at all times. (3-19-07)

h. Statement of policy regarding patient's funds and property. (3-19-07)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (3-19-07)

j. System of periodic review and correction of policies and financial records of patient property and funds. (3-19-07)

614. (RESERVED).

615. ICF/MR - POST-ELIGIBILITY TREATMENT OF INCOME.

01. Treatment of Income. Where an individual is determined eligible for medical assistance 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 IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Sections 721 through 725. (3-19-07)

02. SSA Income. The amount which the Participant receives from SSA as reimbursement for his payment of the premium for Part B of Title XVIII (Medicare) is not considered income for participant liability in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)." (3-19-07)

616. -- 619. (RESERVED).

620. ICF/MR - PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.

Payments may be made for reserving beds in ICFs/MR for participants during their temporary absence if the facility charges private paying participants for reserve bed days, subject to the following limitations: (3-19-07)

01. Prior Approval for Absence. 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 RMS must be obtained for any home visits exceeding fourteen (14) consecutive days. (3-19-07)

02. Limits on Amount of Payments. Payment for reserve bed days will be lesser of the following: (3-19-07)

a. One hundred percent (100%) of the audited allowable costs of the facility; or (3-19-07)

b. The rate charged to private paying participants for reserve bed days. (3-19-07)

621. ICF/MR - PAYMENT PROCEDURES.

Each ICF/MR 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 Participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (3-19-07)

622. ICF/MR - PRINCIPLE PROSPECTIVE RATES.

Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include the following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. (3-19-07)

623. ICF/MR - PROPERTY REIMBURSEMENT.

Beginning October 1, 1996, ICF/MR property costs are reimbursed by a rental rate or based on cost. The following will be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not inconsistent with this chapter: ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and will not be reported in the property cost portion of the cost report. These costs will be reported in the home office and day treatment section of the cost report. Property costs, including costs which are reimbursed based on a rental rate, will be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. Property costs include the following components: (3-19-07)

01. Depreciation. Allowable depreciation based on straight line depreciation. (3-19-07)

02. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. (3-19-07)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. (3-19-07)

04. Lease Payments. All allowable lease or rental payments. (3-19-07)

05. Property Taxes. All allowable property taxes. (3-19-07)

06. Costs of Related Party Leases. Costs of related party leases are to be reported in the property cost

categories based on the owner's costs. (3-19-07)

624. ICF/MR - CAPPED COST.

Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap. (3-19-07)

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. (3-19-07)

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/MR cap and of computing final reimbursement. (3-19-07)

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (3-19-07)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities. (3-19-07)

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap. (3-19-07)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (3-19-07)

05. Costs Which Can be Paid Directly by the Department to Non ICF/MR Providers. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap: (3-19-07)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (3-19-07)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Dental services provided to EPSDT participants who are under the age of twenty-one (21) and who reside in an ICF/MR, are covered under Sections 080 through 085 of these rules. The cost of these services is not includable as a part of ICF/MR costs. Reimbursement can be made to a professional providing these services through his billing the Medicaid Program on his own provider number. (9-1-07)T

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (3-19-07)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base

Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (3-19-07)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (3-19-07)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (3-19-07)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. (3-19-07)

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (3-19-07)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (3-19-07)

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (3-19-07)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. (3-19-07)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (3-19-07)

e. A new cap and rate will be set on an annual basis for each facility the first of July every year. (3-19-07)

f. The cap and prospective rate will be determined and set on an annual basis for each facility July first of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (3-19-07)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. (3-19-07)

h. A facility which commences to offer participant care services as an ICF/MR on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the

Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (3-19-07)

625. ICF/MR - EFFICIENCY INCREMENT.

An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. (3-19-07)

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents (\$.20) per one dollar (\$1) below the cap up to a maximum increment of three dollars (\$3) per participant day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, will not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing participant days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the participant is making payment for holding a bed in the facility, the participant will not be considered to be discharged and thus those days will be counted in the total. (3-19-07)

626. ICF/MR - RETROSPECTIVE SETTLEMENT.

When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (3-19-07)

01. A Provider's Failure to Meet Any of the Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (3-19-07)

02. A First Time Provider. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 603, 605, and 606 of these rules and this chapter. A budget based on the best available information is required prior to opening for participant care so an interim rate can be set. (3-19-07)

03. New ICF/MR Living Unit. A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the non-property rate components based on similar components of rates most recently paid for the participants moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (3-19-07)

04. Change of Ownership of Existing ICF/MR Living Unit. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (3-19-07)

05. Fraudulent or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (3-19-07)

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (3-19-07)

627. ICF/MR - EXEMPT COSTS.

Exempt costs are not subject to the ICF/MR cap.(3-19-07)

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be

reimbursed in this category and may not be subject to the ICF/MR cap. (3-19-07)

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (3-19-07)

b. When a school or another agency or entity is responsible for or pays for services provided to a participant regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by another agency. (3-19-07)

c. When ICF/MR day treatment services are performed for participants in a licensed Developmental Disability Center, the allowable cost of such services will be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and will be reported as non-reimbursable. (3-19-07)

d. For day treatment services provided in a location other than a certified developmental disability center, the maximum amount reportable in this category will also be limited. Total costs for such services reported by each provider in this category will be limited to the number of hours, up to thirty (30) hours per week per participant, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection will be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates will be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (3-19-07)

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, will be separately identified, will be reported as day treatment services costs, and will not include property costs otherwise reimbursed. Property costs related to day treatment services will be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or will be separate and distinct from any property used for ICF/MR services which are or were day treatment services. (3-19-07)

f. In the event a provider has a change in the number of participants requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. (3-19-07)

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter will be exempt from the ICF/MR cap and will be reimbursed prospectively based on Medicare principles of cost reimbursement. (3-19-07)

628. ICF/MR - COSTS EXCLUDED FROM THE CAP.

Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (3-19-07)

01. Increases of More Than One Dollar Per Participant Day in Costs. Increases of more than one dollar (\$1) per participant day in costs otherwise subject to the cap incurred by a facility as a result of changes in State

or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (3-19-07)

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (3-19-07)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (3-19-07)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (3-19-07)

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (3-19-07)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at its option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (3-19-07)

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (3-19-07)

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (3-19-07)

03. Cost Increases Greater Than Three Percent. When cost increases of greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. Prospective rates will be increased and they will not be subject to the cap. However, they may be retrospectively adjusted by the Department. For the purposes of this Subsection, disaster does not include personal or financial problems. (3-19-07)

04. Decreases. In the event of state or federal law, rule, or policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (3-19-07)

05. Prospective Negotiated Rates. Notwithstanding the provisions of Section 622 of these rules, the Director will have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates will not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (3-19-07)

629. ICF/MR - LEGAL CONSULTANT FEES AND LITIGATION COSTS.

Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (3-19-07)

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (3-19-07)

02. Administrative Appeals. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (3-19-07)

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (3-19-07)

630. ICF/MR - PROPERTY RENTAL RATE REIMBURSEMENT.

ICFs/MR will be paid a property rental rate. Property taxes, property insurance, and depreciation expense or major moveable equipment will be reimbursed as costs exempt from limitations. The property rental rate does not include compensation for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. See Sections 56-108 and 56-109, Idaho Code, for further clarification. (3-19-07)

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to the following: (3-19-07)

a. $R = \text{"Property Base"} \times 40 - \text{"Age"} / 40 \times \text{"change in building costs"}$ where: (3-19-07)

b. "R" = the property rental rate. (3-19-07)

c. "Property Base" = eleven dollars and twenty-two cents (\$11.22) except for ICF/MR living units not able to accommodate residents requiring wheelchairs beginning October 1, 1996. Property base = seven dollars and twenty-two cents (\$7.22) for ICF/ MR living units not able to accommodate residents requiring wheelchairs. (3-19-07)

d. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. For ICF/MR facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used. (3-19-07)

e. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (3-19-07)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 630.01.d.ii.

If the result of this calculation, “r” is equal to or greater than two point zero (2.0), the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (3-19-07)

ii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 630.01.d.i. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate “r” for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for “C” will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (3-19-07)

iii. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars (\$100) per bed. If the cost related to the requirement is less than one hundred dollars (\$100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (3-19-07)

iv. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 630.01.d.iii. and 630.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (3-19-07)

v. Effective October 1, 1996, for ICF/ MR facilities, “age of facility” will be a revised age which is the lesser of the age established under other provisions of this Section or the age which most closely yields the rate allowable to existing facilities as of September 30, 1996, under Subsection 630.01 of these rules. This revised age will not increase over time. (3-19-07)

02. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 630.01 of these rules. (3-19-07)

631. ICF/MR - PROPERTY REIMBURSEMENT LIMITATIONS.

Beginning October 1, 1996, property costs of an ICF/MR will be reimbursed in accordance with Section 630 of these rules except as follows: (3-19-07)

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 630 of these rules will apply to ICF/MR facilities. (3-19-07)

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/MR living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs will not include costs reimbursed by, or covered by the property rental rate. Such costs will only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/MR living units within four (4) licensable beds. (3-19-07)

03. Leases for Property. Beginning October 1, 1996, ICF/MR facilities with leases will be reimbursed as follows: (3-19-07)

a. The property costs related to ICF/MR living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Section 630 of these rules. (3-19-07)

b. Leases for property other than ICF/MR living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. (3-19-07)

632. ICF/MR - SPECIAL RATES.

Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to consumers who have medical or behavior long-term care needs beyond the normal scope of facility services. These individuals must have one (1) or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include but are not limited to individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 632 of these rules, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-19-07)

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. (3-19-07)

02. Approval. Special rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances: (3-19-07)

a. New admissions to a community ICF/MR; (3-19-07)

b. For individuals currently living in a community ICF/MR when there has been a significant change in condition not reflected in the current rate; or (3-19-07)

c. The facility has altered services to achieve and maintain compliance with state licensing or federal certification requirements that have resulted in additional cost to the facility not reflected in their current rate. (3-19-07)

d. For the purpose of this rule, an emergency exists when the facility must incur additional behavioral or medical costs to prevent a more restrictive placement. (3-19-07)

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (3-19-07)

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other participants for similar services. (3-19-07)

633. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES. Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars (\$5,000). (3-19-07)

634. -- 649. (RESERVED).

650. DEVELOPMENTAL DISABILITIES AGENCIES (DDA). 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 certified 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 assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (3-19-07)

651. (RESERVED).

652. DEVELOPMENTAL DISABILITIES AGENCY (DDA) SERVICES - ELIGIBILITY. Prior to receiving services in a DDA an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code. (3-19-07)

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

a. All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. All therapy services for adults with developmental disabilities and ISSH waiver participants must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

02. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies": (3-19-07)

a. Comprehensive Developmental Assessment; (3-19-07)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to

complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in this subsection; (3-19-07)

- c.** Occupational Therapy Assessment (3-19-07)
- d.** Physical Therapy Assessment; (3-19-07)
- e.** Speech and Language Assessment; (3-19-07)
- f.** Medical/Social History; and (3-19-07)
- g.** Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)

03. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. (3-19-07)

b. Psychotherapy Services. Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include: (3-19-07)

- i.** Individual psychotherapy; (3-19-07)
- ii.** Group psychotherapy; and (3-19-07)
- iii.** Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one-to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (3-19-07)

d. Speech 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. (3-19-07)

e. Physical Therapy. Physical therapy services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 730 through 737. Physical therapy includes individual or group therapy. (3-19-07)

f. Occupational Therapy. Occupational therapy includes individual occupational therapy and group occupational therapy. (3-19-07)

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

h. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-19-07)

i. Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (3-19-07)

j. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (3-19-07)

04. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

a. The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed thirty (30) hours per week. (3-19-07)

b. Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. (3-19-07)

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (3-19-07)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (3-19-07)

e. Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856. (3-19-07)

654. -- 655. (RESERVED).

656. DDA SERVICES - PROVIDER REIMBURSEMENT.
Payment for agency services must be in accordance with rates established by the Department. (3-19-07)

657. -- 699. (RESERVED).

700. INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES/ISSH - WAIVER SERVICES.
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. (3-19-07)

701. (RESERVED).

702. DD/ISSH WAIVER SERVICES - ELIGIBILITY.

Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. 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: (3-19-07)

01. Age of Participants. 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. (3-19-07)

02. Eligibility Determinations. The Department must determine that: (3-19-07)

a. The participant would qualify for ICF/MR level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and (3-19-07)

b. 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. (3-19-07)

c. 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. (7-1-06)

d. 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. (3-19-07)

03. Home and Community Based Services Waiver Eligible Participants. 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. (3-19-07)

04. Processing Applications. 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. (3-19-07)

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-19-07)

06. Case Redetermination. (3-19-07)

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. (3-19-07)

- b.** The redetermination process will assess the following factors: (3-19-07)
- i. The participant's continued need and eligibility for waiver services; and (3-19-07)
- ii. Discharge from the waiver services program. (3-19-07)

07. 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 30th for the DD waiver and after June 30th for the ISSH waiver of each new waiver year. (3-19-07)

703. DD/ISSH WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce

habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

13. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for persons with Mental Retardation (ICF/MR); and (3-19-07)

- c. Residential Care or Assisted Living Facility. (3-19-07)
- d. Additional limitations to specific services are listed under that service definition. (3-19-07)

704. DD/ISSH WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. 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 Sections 507 through 520 of these rules. 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. (3-19-07)

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (3-19-07)

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: (3-19-07)

- i. Date and time of visit; and (3-19-07)
- ii. Services provided during the visit; and (3-19-07)
- 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 (3-19-07)
- 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. (3-19-07)

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. (3-19-07)

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 704.01 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. (3-19-07)

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 Sections 507 through 520 of these rules. (3-19-07)

03. 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. (3-19-07)

04. 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 participant's records for five (5) years following the date of service. (3-19-07)

705. DD/ISSH WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation. 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 residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-19-07)

- a.** Direct service staff must meet the following minimum qualifications: (3-19-07)
 - i.** Be at least eighteen (18) years of age; (3-19-07)
 - ii.** Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)
 - iii.** Have current CPR and First Aid certifications; (3-19-07)
 - iv.** Be free from communicable diseases; (3-19-07)
 - v.** Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)
 - vi.** Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T
 - vii.** Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)
 - b.** All skill training for direct service staff must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. (3-19-07)
 - c.** Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-19-07)
 - i.** Purpose and philosophy of services; (3-19-07)
 - ii.** Service rules; (3-19-07)
 - iii.** Policies and procedures; (3-19-07)
 - iv.** Proper conduct in relating to waiver participants; (3-19-07)
 - v.** Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)
 - vi.** Participant rights; (3-19-07)
 - vii.** Methods of supervising participants; (3-19-07)
 - viii.** Working with individuals with developmental disabilities; and (3-19-07)
 - ix.** Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-19-07)

- i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)
- ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)
- iii. Feeding; (3-19-07)
- iv. Communication; (3-19-07)
- v. Mobility; (3-19-07)
- vi. Activities of daily living; (3-19-07)
- vii. Body mechanics and lifting techniques; (3-19-07)
- viii. Housekeeping techniques; and (3-19-07)
- ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

f. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider's provider agreement. (3-19-07)

02. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

- a.** Be skilled in the type of service to be provided; and (3-19-07)
- b.** Demonstrate the ability to provide services according to a plan of service. (3-19-07)
- c.** Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

03. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

- a.** Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)
- b.** Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)
- c.** Demonstrate the ability to provide services according to an plan of service; (3-19-07)
- d.** Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)
- e.** Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

- f. Be free of communicable diseases. (3-19-07)
- g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T
- 04. Supported Employment.** Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T
- 05. Transportation.** Providers of transportation services must: (3-19-07)
 - a. Possess a valid driver's license; and (3-19-07)
 - b. Possess valid vehicle insurance. (3-19-07)
- 06. Environmental Accessibility Adaptations.** Environmental accessibility adaptations services must: (3-19-07)
 - a. Be done under a permit, if required; and (3-19-07)
 - b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)
- 07. Specialized Equipment and Supplies.** Specialized Equipment and Supplies purchased under this service must: (3-19-07)
 - a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)
 - b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)
- 08. Personal Emergency Response System.** Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)
- 09. Home Delivered Meals.** Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (3-19-07)
 - a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)
 - b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)
 - c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)
 - d. Provide documentation of current driver's license for each driver; and (3-19-07)
 - e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

10. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

11. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Mental Retardation Professional (QMRP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (1-1-07)T

12. Adult Day Care. 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 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: (3-19-07)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (1-1-07)T

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

13. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

706. DD/ISSH WAIVER SERVICES - PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-19-07)

707. -- 719. (RESERVED).

SUB AREA: SERVICE COORDINATION SERVICES

(Sections 720 Through 779)

720. SERVICE COORDINATION.

The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. (3-19-07)

721. SERVICE COORDINATION - DEFINITIONS.

01. Agency. An agency is a business entity that provides service coordination and includes at least a supervisor and a service coordinator. (3-19-07)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

- a.** Hospitalization; (3-19-07)
- b.** Loss of housing; (3-19-07)
- c.** Loss of employment or major source of income; (3-19-07)
- d.** Incarceration; or (3-19-07)
- e.** Physical harm to self or others, including family altercation or psychiatric relapse. (3-19-07)

04. Crisis Service Coordination. Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. (3-19-07)

05. Current Assessment. An assessment that accurately reflects the status of the participant. (3-19-07)

06. High Cost Services. As used in Subsection 725.01 of these rules, high cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include: (3-19-07)

- a.** Emergency room visits or procedures; (3-19-07)
- b.** Inpatient medical and psychiatric services; (3-19-07)
- c.** Nursing home admission and treatment; (3-19-07)
- d.** Institutional care in jail or prison; (3-19-07)

- e. State, local, or county hospital treatment for acute or chronic illness; and (3-19-07)
- f. Outpatient hospital services. (3-19-07)
- 07. Human Services Field.** A particular area of academic study in health, social services, education, behavioral science or counseling. (3-19-07)
- 08. Paraprofessional.** An adult who has a minimum of a bachelor's degree in a human services field but no experience with participants, or a person without a degree but with a high school diploma or equivalency who has at least twelve (12) months' experience with the population to whom they will be providing services. (3-19-07)
- 09. Practitioner of the Healing Arts.** For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)
- 10. 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. Service coordination is a brokerage model of case management. (3-19-07)
- 11. 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 in Section 729 of these rules. (3-19-07)
- 12. Supports.** Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (3-19-07)
- 722. SERVICE COORDINATION SERVICES - ELIGIBILITY.**
Participants identified in Sections 723 through 726 of these rules, who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, are eligible for service coordination. (3-19-07)
- 723. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.**
Individuals with a developmental disability as defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, are eligible for service coordination if they meet the following. (3-19-07)
 - 01. Age.** Are adults eighteen (18) years of age or older, or adolescents fifteen to eighteen (15-18) years of age who are authorized to receive services through the Idaho State School and Hospital (ISSH) waiver; and (3-19-07)
 - 02. Diagnosis.** Are diagnosed with a developmental disability, which means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (3-19-07)
 - a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition 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 (3-19-07)
 - b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)
 - c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated; and (3-19-07)
 - 03. Need Assistance.** Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community. (3-19-07)

724. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WHO RECEIVE PERSONAL ASSISTANCE SERVICES.

Individuals who receive personal assistance services are eligible for service coordination if they: (3-19-07)

01. Personal Care Services. Are adults or children who have been approved to receive state plan personal care services; or (3-19-07)

02. Waiver Services. Are adults who have been approved to receive Aged and Disabled Home and Community Based Services Waiver; and (3-19-07)

03. Need Assistance. Require and choose assistance to access services and supports necessary to maintain their independence in the community. (3-19-07)

725. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS.

Adults with severe and persistent mental illness are eligible for service coordination if they: (3-19-07)

01. Adults Using High Cost Services. Are eighteen (18) years of age or older and using, or have a history of using, high cost medical services associated with periods of increased severity of mental illness; and (3-19-07)

02. Diagnosis of Mental Illness. (3-19-07)

a. Are diagnosed by a licensed physician or other licensed practitioner of the healing arts (licensed psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage or family therapist) with a condition of severe and persistent mental illness that is listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) within one (1) of the following classification codes: (3-19-07)

i. Schizophrenia and other psychotic disorders; (3-19-07)

ii. Delirium, dementia, and amnestic disorders; other cognitive disorders; and mental disorders due to a general medical condition; (3-19-07)

iii. Mood disorders - bipolar and depressive; (3-19-07)

iv. Schizoid, schizotypal, paranoid or borderline personality disorders; and (3-19-07)

b. If the only diagnosis is mental retardation or is a substance related disorder, then the person is not included in the target population for mental health service coordination. (3-19-07)

03. Need Assistance. Have mental illness of sufficient severity to cause a disturbance in their role performance or coping skills in at least two (2) of the following areas, on either a continuous (more than one (1) year) or an intermittent (at least once per year) basis: (3-19-07)

a. Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history. (3-19-07)

b. Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support himself or manage his finances without assistance. (3-19-07)

c. Social and interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (3-19-07)

d. Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child,

or faces gross familial disruption or imminent exclusion from the family. (3-19-07)

e. Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (3-19-07)

f. Housing: Has lost or is at risk of losing his current residence. (3-19-07)

g. Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior, which may result in intervention by law enforcement, the judicial system, or both. (3-19-07)

h. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens. (3-19-07)

726. SERVICE COORDINATION - ELIGIBILITY - CHILDREN UP TO THE AGE OF TWENTY-ONE.
To be eligible for service coordination under the Early and Periodic Screening Diagnosis and Treatment program (EPSDT), children must meet the following: (3-19-07)

01. Age. Children from birth through the month in which their twenty first birthday occurs; and (3-19-07)

02. Diagnosis. Must be identified by a physician or other practitioner of the healing arts in an EPSDT screen as having one (1) of the diagnoses found in Subsections 726.03 through 726.05 of these rules. (3-19-07)

03. Developmental Delay or Disability. A physical or mental condition which has a high probability of resulting in developmental delay or disability, or children who meet the definition of developmental disability as defined in Section 66-402, Idaho Code. (3-19-07)

04. Special Health Care Needs. Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability. (3-19-07)

05. Serious Emotional Disturbance (SED). Have a serious emotional disturbance (SED) with an expected duration of at least one (1) year. The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code. (3-19-07)

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 (3-19-07)

b. Requires sustained treatment interventions; and (3-19-07)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-19-07)

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 on the CAFAS or a full seven (7) scale score of eighty (80) or higher on the PECFAS with "moderate" impairment in at least one (1) of the following three (3) scales: (3-19-07)

i. Self-Harmful Behavior; (3-19-07)

ii. Moods/Emotions; or (3-19-07)

iii. Thinking. (3-19-07)

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. (3-19-07)

- 06. Need Assistance.** Have one (1) or more of the following problems associated with their diagnosis: (3-19-07)
- a.** The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, family, or community; or (3-19-07)
 - b.** The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; or (3-19-07)
 - c.** There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; or (3-19-07)
 - d.** Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)
 - e.** The child requires multiple service providers and treatments. (3-19-07)
- 727. SERVICE COORDINATION - COVERAGE AND LIMITATIONS.** (3-19-07)
Service coordination consists of the following functions: (3-19-07)
- 01. Linking the Participant to Needed Services.** “Linking” includes: (3-19-07)
- a.** Finding, arranging and assisting the participant to maintain services, supports, and community resources identified on the service plan; and (3-19-07)
 - b.** Advocating for the unmet needs of the participant and to encourage independence. (3-19-07)
- 02. Monitoring and Coordination of Services.** Monitoring and coordinating services includes: (3-19-07)
- a.** Assisting the participant and his family or guardian to coordinate and retain services, and assure consistency and non-duplication between services; and (3-19-07)
 - b.** Assuring that services are satisfactory to the participant and making adjustments in the plan of service when needed. (3-19-07)
- 03. Assessment.** Assessment for service coordination includes evaluation of the participant's ability to: gain access to needed services; coordinate or maintain those services; and identify the services and supports the participant needs to maintain his highest level of independence in the community. The assessment is an interactive process with maximum feasible involvement of the participant. (3-19-07)
- a.** **Assessment Content for Developmental Disability.** A person with a developmental disability is assessed through the developmental disability eligibility criteria identified in Section 66-402, Idaho Code. The need for assistance, as defined in Sections 723 through 726 of these rules, must be determined through the person centered planning process as defined in IDAPA 16.04.11, “Developmental Disabilities Agencies,” Section 011. (3-19-07)
 - b.** **Assessment Content for Personal Assistance Services.** A comprehensive evaluation of the participant's ability to function in the community including: (3-19-07)
 - i.** Medical needs, physical problems and strengths; (3-19-07)
 - ii.** Mental and emotional problems and strengths; (3-19-07)
 - iii.** Physical living environment; (3-19-07)
 - iv.** Vocational and educational needs; (3-19-07)

- v. Financial and social needs; (3-19-07)
 - others; vi. Evaluation of the community support system including the involvement of family or significant others; (3-19-07)
 - vii. Safety and risk factors; and (3-19-07)
 - viii. Legal status. (3-19-07)
- c. Assessment Content for Mental Health. The assessment must focus on the following areas: (3-19-07)
 - i. Mental status (psychiatric status for individuals with mental illness); (3-19-07)
 - ii. Medical history and needs; (3-19-07)
 - iii. Vocational status and needs; (3-19-07)
 - iv. Financial status and needs; (3-19-07)
 - v. Social relationships and supports; (3-19-07)
 - vi. Family status and supports; (3-19-07)
 - vii. Basic living skills and needs; (3-19-07)
 - viii. Housing status and needs; and (3-19-07)
 - ix. Community and legal status and needs. (3-19-07)
- d. EPSDT Assessment. The assessment for EPSDT Service Coordination services is completed by the Department. (3-19-07)
- 04. Crisis Assistance.** (3-19-07)
 - a. Crisis Assistance. Crisis assistance, including services to prevent hospitalization or incarceration, may be provided before the completion of assessment and development of a plan of service. (3-19-07)
 - b. Crisis Assistance for Children Receiving EPSDT Service Coordination. Additional crisis hours may be authorized for service coordination for children receiving EPSDT service coordination if at least four (4) hours of service coordination have already been provided in the month. (3-19-07)
 - c. Crisis Assistance for Adults With a Developmental Disability. Crisis assistance for adults with a developmental disability may be authorized under community crisis supports as found in Section 507 through 515 of these rules. (3-19-07)
 - d. Crisis Assistance for Adults With Severe and Persistent Mental Illness. Crisis assistance may be delivered prior to, or after, the completion of the assessment and individual service plan. Without authorization by the Department crisis assistance is limited to a total of three (3) hours per calendar month. The Department may authorize additional crisis case management services beyond the three (3) hour limit if a participant still has severe or prolonged crisis case management needs that meet all of the following criteria: (3-19-07)
 - i. The service participant is at imminent risk within fourteen (14) days of hospitalization or institutionalization, including jail or nursing home; and (3-19-07)
 - ii. The service participant is experiencing symptoms of psychiatric decompensation; and (3-19-07)

iii. The service participant has already received the maximum number of monthly hours of ongoing case management and crisis case management services; and (3-19-07)

iv. No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (3-19-07)

e. Crisis Assistance for Individuals Who Receive Personal Assistance Services. Additional hours for crisis assistance may be authorized for individuals who receive personal assistance services, if at least eight (8) hours of service coordination have already been provided in the month. (3-19-07)

05. Limitations on the Provision of Direct Services. Providers of service coordination services may not provide both service coordination and direct service to the same Medicaid participant except for the following: (3-19-07)

a. Early and Periodic Screening Diagnosis and Treatment (EPSDT). Providers of service coordination to children under the EPSDT option; or (3-19-07)

b. Adults With Severe and Persistent Mental Illness. Providers of service coordination to adults with severe and persistent mental illness. (3-19-07)

06. Limitations on Service Coordination. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as service coordination services. Service coordination is limited to the following: (3-19-07)

a. Service Coordination for Persons With Mental Illness. Five (5) hours per month for participants with mental illness. (3-19-07)

b. Service Coordination for Personal Assistance Services. Up to eight (8) hours per month for participants who have been approved to receive personal assistance services, as prior authorized by the Department. (3-19-07)

c. Other Populations. Service coordination services to participants with developmental disabilities and children under the EPSDT option are prior authorized by the Department on a monthly basis. (3-19-07)

d. Assessment and Plan Development. Assessment and plan development are reimbursable except for the initial plan development for EPSDT service coordination. (3-19-07)

e. Initial Plan Development. Reimbursement for the initial evaluation and individual service plan development will be paid based on an hourly rate, not to exceed six (6) hours. (3-19-07)

728. SERVICE COORDINATION - PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. All service coordination services must be prior authorized by the Department, except the following adult mental health service coordination services: initial assessment for services; five (5) hours of ongoing service coordination per month; and the first three (3) hours of crisis service coordination per month. For adults with mental illness, crisis service coordination over three (3) hours per month must be prior authorized. (3-19-07)

02. Service Plan Development. A written service coordination plan must be developed and implemented within sixty (60) days after the participant chooses a service coordination agency except in the case of adults with severe and persistent mental illness; in which case the time limit is thirty (30) days. The plan must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. (3-19-07)

a. Service Plan Content for Individuals With Developmental Disabilities. The service coordination plan for individuals with developmental disabilities is incorporated into the participant's plan of service. The content

is identified in Section 512 of these rules. (3-19-07)

b. Service Plan Content for Individuals Receiving Personal Assistance Services. The individual's service plan must contain at least the following: (3-19-07)

i. Problems identified during the assessment; (3-19-07)

ii. Overall goals to be achieved; (3-19-07)

iii. Reference to all services and contributions provided by the informal support system including the actions, if any, taken by the service coordinator to develop the support system; (3-19-07)

iv. Documentation of who has been involved in the service planning, including the participant's involvement; (3-19-07)

v. Schedules for service coordination monitoring and reassessment; (3-19-07)

vi. Documentation of unmet needs and service gaps; and (3-19-07)

vii. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery. (3-19-07)

c. Service Plan Content for Individuals With Severe And Persistent Mental Illness. The service coordination plan must include the following: (3-19-07)

i. A list of problems and needs identified during the assessment; (3-19-07)

ii. Concrete measurable goals and objectives to be achieved by the service coordinator; (3-19-07)

iii. Time frames for achievement of the goals and objectives; (3-19-07)

iv. Reference to any formal services arranged including specific providers; (3-19-07)

v. Frequency of services initiated; and (3-19-07)

vi. Documentation of who was involved in the service planning. (3-19-07)

d. Service Plan Development for EPSDT Service Coordination. The initial plan for EPSDT service coordination is completed by the Department or designee. An EPSDT service coordination agency selected by the family develops an annual service coordination plan and submits it to the Department for prior authorization of continued service coordination. (3-19-07)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (3-19-07)

a. Name. The name of the eligible participant. (3-19-07)

b. Provider. The name of the provider agency and the person providing the direct services. (3-19-07)

c. Time and Place of Service. The date, time and place the service was provided. (3-19-07)

d. Documentation of Eligibility. A copy of the current assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed service plan. (3-19-07)

e. Description. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (3-19-07)

f. Progress Review. Review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. (3-19-07)

g. Satisfaction With Service. Documentation of the participant's, family's, or guardian's satisfaction with service. (3-19-07)

h. Informed Consent. A copy of the informed consent form signed by the participant or guardian which documents that the participant has been informed of his rights to refuse service coordination and to choose his providers. (3-19-07)

i. Service Plan. A service plan that is signed by the participant or his legal representative, and the plan developer. Mental health service coordination plans must also be signed by a physician or other practitioner of the healing arts. The service coordinator must also document that a copy of the plan was given to the participant or his legal representative. The plan must be updated and authorized when required, but at least annually. (3-19-07)

j. Crisis Assistance Documentation for Adults With Severe and Persistent Mental Illness. Documentation to support authorization of crisis assistance beyond the monthly limitation must be submitted to the Department before such authorization may be granted. Documentation to support delivery of crisis assistance must also be maintained in the participant's agency record and must include: (3-19-07)

i. A description of the crisis, including identification of unanticipated events that precipitate the need for crisis case management services; (3-19-07)

ii. A brief review of case management and other services or supports available to, or already provided to, the participant to resolve the crisis; (3-19-07)

iii. A crisis resolution plan; and (3-19-07)

iv. Outcomes of crisis assistance service provision. (3-19-07)

04. Participant Choice of Service Coordination Providers. Eligible participants have the option to select service coordinators. A participant must have free choice of a service coordination provider. (3-19-07)

05. Service Coordinator Contact and Availability. At least every thirty (30) days, service coordinators must have contact with the participant, legal guardian or provider who can verify the participant's well being and whether services are being provided according to the written plan. The frequency, mode of contact, and person being contacted must be identified in the plan. (3-19-07)

a. The mode and frequency of contact for developmental disability service coordination must be identified in the plan and must meet the needs of the participant. Service coordinators must have face-to-face contact with each participant at least every ninety (90) days. (3-19-07)

b. The mode and frequency of contact for mental health service coordination must be identified in the plan and must meet the needs of the participant. Mental health service coordinators must have face-to-face contact every month with each participant. (3-19-07)

c. The mode and frequency of contact for Early and Periodic Screening and Diagnosis and Treatment (EPSDT) service coordination must be identified in the plan and must meet the needs of the child. EPSDT service coordinators must have face to face contact with the child and the child's family at least every ninety (90) days. (3-19-07)

d. The mode and frequency of contact for Personal Care Service (PCS) service coordination must be identified in the plan and must meet the needs of the participant. PCS service coordinators must have face to face

contact with the participant and others at least every ninety (90) days as necessary to coordinate and monitor the progress of the existing individual service plan. (3-19-07)

e. Hours of Availability. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include on the plan what the participant, families, and providers should do in an emergency situation. (3-19-07)

729. SERVICE COORDINATION - PROVIDER QUALIFICATIONS.

Services will be provided by an organized provider agency that has entered into a provider agreement with the Department. (3-19-07)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Work Experience and Supervision. All service coordinators must have at least twelve (12) months' experience working with the population they will be serving or be supervised by a qualified service coordinator. (3-19-07)

03. Minimum Education Requirements. All service coordinators must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse, also referred to as a registered nurse (RN). (3-19-07)

04. Mandatory Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Criminal History and Background Checks." (3-19-07)

05. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

730. SERVICE COORDINATION - PARAPROFESSIONALS.

Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan except for plans of participants with a mental illness. Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service. (3-19-07)

731. SERVICE COORDINATION - SUPERVISION OF SERVICE COORDINATION.

Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed by the agency. Agency supervisors must have the following qualifications: (3-19-07)

01. Master's Degree. Master's degree in a human services field and one (1) year's experience with the population for whom they will be supervising services. For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting; or (3-19-07)

02. Bachelor's Degree. Bachelor's degree in a human services field or RN degree and two (2) years' experience with the population for whom they will be supervising services. For supervisors of service coordination to participants with mental illness, this experience must be in a mental health service setting. (3-19-07)

732. SERVICE COORDINATION - INDIVIDUAL SERVICE COORDINATOR CASE LOADS.

The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (3-19-07)

733. -- 735. (RESERVED).

736. SERVICE COORDINATION - PROVIDER REIMBURSEMENT.

- 01. Limitations on Payment for Service Coordination.** (3-19-07)
- a.** Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)
- b.** Payment for Service Coordination. Subject to the service limitations in Subsection 736.01.F of this rule, only the following services are reimbursable: (3-19-07)
- i.** Face to face contact as required in Subsection 728.05 of these rules. (3-19-07)
- ii.** Telephone contact between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal representative, or other interested persons; or (3-19-07)
- iii.** Face to face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)
- iv.** Paperwork that is associated with obtaining certain needed services such as food stamps, energy assistance, emergency housing, or legal services. (3-19-07)
- c.** Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. Service coordination may be provided during the last thirty (30) days of an inpatient stay, or if the stay is not expected to last longer than thirty (30) days, when the service does not duplicate the discharge responsibilities of the facility. (3-19-07)
- d.** Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)
- e.** Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the assessment and service plan. (3-19-07)
- f.** 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 service coordination paid at an hourly rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period. (3-19-07)
- 02. Healthy Connections.** If the participant is enrolled in Healthy Connections, the referral for assessment and provision of services must be authorized by a physician or other practitioner of the healing arts, except for participants who receive personal care services or aged and disabled waiver services. (3-19-07)
- 03. Group Service Coordination.** Payment is not allowed for service coordination provided to a group of participants. (3-19-07)
- 737. -- 779. (RESERVED).**

SUB AREA: BREAST AND CERVICAL CANCER PROGRAM

(Sections 780 Through 799)

- 780. BREAST OR CERVICAL CANCER PROGRAM THROUGH THE WOMEN'S HEALTH CHECK.** Women who are determined eligible for Medicaid through the Women's Health Check program are eligible for enhanced Medicaid benefits until it is determined that cancer treatment has ended. (3-19-07)
- 781. BREAST OR CERVICAL CANCER PROGRAM - DEFINITIONS.**

01. Primary Treatment. The initial action of treating a patient medically or surgically for cancer using conventional treatment modalities. (3-19-07)

02. Adjuvant Therapy. Treatment that includes either radiation or systemic chemotherapy, or both, as part of the plan of care. (3-19-07)

03. End of Treatment. Cancer treatment ends: (3-19-07)

a. When the woman's plan of care reflects a status of surveillance, follow-up, or maintenance mode; or (3-19-07)

b. If the woman's treatment relies on an unproven procedure, as referred to in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 390 in lieu of primary or adjuvant treatment. (3-19-07)

782. BREAST OR CERVICAL CANCER PROGRAM - ELIGIBILITY.

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. (3-19-07)

783. BREAST OR CERVICAL CANCER PROGRAM - PROCEDURAL REQUIREMENTS.

The Division of Medicaid, or its successor, is responsible for determining when a woman's treatment has ended. (3-19-07)

784. -- 999. (RESERVED).

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than.....	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper.....	2-4 mm = 0	

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower.....	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	
TOTAL SCORE: _____		
Scoring Definitions: Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids. a) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch. b) Missing teeth count as 1, if the space is still present. c) Do not score teeth that are not fully erupted. d) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.		

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