IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.09 – Medicaid Basic Plan Benefits

Who does this rule apply to?
For those seeking medical assistance under Idaho Medicaid's Basic Plan and for Medicaid providers.

What is the purpose of this rule?
This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program (Medicaid). All goods and services not specifically included in this chapter are excluded from coverage under the Medicaid Basic Plan. A guide to covered services is found under Section 399 of these rules. These rules also contain requirements for provider procurement and provider reimbursement. (For Medicaid eligibility, please see IDAPA 16.03.01,"Eligibility for Health Care Assistance for Families and Children.")

What is the legal authority for the agency to promulgate this rule?
This rule implements the following "Public Assistance Law" statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-264, Idaho Code – Rulemaking Authority

Idaho Intermediate Care Facility Assessment Act:
- Section 56-1610, Idaho Code – Rulemaking Authority

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Medicaid – Basic Plan Benefits
3232 West Elder Street
Boise, ID 83705

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5747 or 1-877-200-5441 (toll free)
Fax: (208) 364-1811
Email: Medicaid.Rules@dhw.idaho.gov
Webpages: http://medicaid.Idaho.gov and https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx

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000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, and 56-1610, Idaho Code. (3-29-12)

02. General Administrative Authority. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-30-07)

03. Administration of the Medical Assistance Program. (3-30-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-30-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-30-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. (3-29-12)

04. Fiscal Administration. (3-30-07)

a. Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-30-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-30-07)

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-30-07)

02. Scope. This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program. All goods and services not specifically included in this chapter are excluded from coverage under the Medicaid Basic Plan. A guide to covered services is found under Section 399 of these rules. These rules also contain requirements for provider procurement and provider reimbursement. (3-30-07)

002. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. (3-20-20)

003. (RESERVED)

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-30-07)

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: http://www.asha.org/policy/ps2004-00098.htm. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-29-10)

02. DSM-5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Arlington, VA, American Psychiatric Association, 2013. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-20-14)

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines

Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual. (7-1-17)

05. 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 website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-30-07)

06. 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.idaho.gov. (3-30-07)

005. -- 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, and Misconduct." (3-30-07)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. Availability to Work or Provide Service. (3-30-07)

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 records. (3-30-07)

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. (3-30-07)

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. (3-30-07)

04. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (3-30-07)

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 870.02 of these rules. (4-7-11)

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. (3-20-14)

010. DEFINITIONS: A THROUGH H.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman. (3-30-07)

02. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-30-07)

03. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (3-30-07)

04. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-30-07)

05. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-30-07)

06. Audit Reports. (3-30-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-30-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-30-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-30-07)

07. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-30-07)

08. Basic Plan. The medical assistance benefits included under this chapter of rules. (3-30-07)

09. Buy-In Coverage. The amount the State pays for Part B of Title XVIII of the Social Security Act on behalf of the participant. (3-30-07)

10. Certified Registered Nurse Anesthetist (CRNA). A Licensed Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. (3-30-07)

11. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-30-07)

12. **CFR**. Code of Federal Regulations. (3-30-07)

13. **Clinical Nurse Specialist (CNS)**. A licensed registered 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." (7-1-17)

14. **CMS**. Centers for Medicare and Medicaid Services. (3-30-07)

15. **CMS/Medicare DME Coverage Manual**. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual. (7-1-17)

16. **Co-Payment**. The amount a participant is required to pay to the provider for specified services. (3-30-07)

17. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-30-07)

18. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM. (3-30-07)

19. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-30-07)

20. **Director**. The Director of the Idaho Department of Health and Welfare or their designee. (3-30-07)

21. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. (3-30-07)

22. **Durable Medical Equipment (DME)**. Equipment and appliances that: (7-1-17)

a. Are primarily and customarily used to serve a medical purpose; (7-1-17)

b. Are generally not useful to an individual in the absence of a disability, illness, or injury; (7-1-17)

c. Can withstand repeated use; (7-1-17)

d. Can be reusable or removable; (7-1-17)

e. Are suitable for use in any setting in which normal life activities take place; and (7-1-17)

f. Are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)

23. **Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-30-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-30-07)

b. Serious impairment to bodily functions. (3-30-07)

c. Serious dysfunction of any bodily organ or part. (3-30-07)

24. **EPSDT**. Early and Periodic Screening, Diagnosis, and Treatment. (3-30-07)

25. **Facility**. Facility refers to a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. (3-30-07)

26. **Federally Qualified Health Center (FQHC)**. An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. (3-30-07)

27. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (3-30-07)

28. **Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (3-30-07)

29. **Home Health Services**. Services and items that are: (7-1-17)

a. Ordered by a physician as part of a home health plan of care; (7-1-17)

b. Performed by a licensed, qualified professional; (7-1-17)

c. Typically received by a Medicaid participant at the participant's place of residence; and (7-1-17)

d. Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)

30. **Hospital**. A hospital as defined in Section 39-1301, Idaho Code. (3-30-07)

31. **Hospital-Based Facility**. A nursing facility that is owned, managed, or operated by, or is otherwise a part of a licensed hospital. (3-30-07)

011. DEFINITIONS: I THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. **ICF/ID**. Intermediate Care Facility for People with Intellectual Disabilities. An ICF/ID is an entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-30-07)

02. **Idaho Behavioral Health Plan (IBHP)**. The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. (3-20-14)

03. **Idaho Infant Toddler Program (ITP)**. The Idaho Infant Toddler Program serves children from birth through the end of their 36th month of age, who meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C. (7-1-18)

04. **In-Patient Hospital Services**. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

05. **Intermediary**. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

06. **Intermediate Care Facility Services**. Those services furnished in an intermediate care facility as

defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

07. **Legal Representative**. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

08. **Legend Drug**. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

09. **Level of Care**. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

10. **Licensed, Qualified Professionals**. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

11. **Lock-In Program**. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

12. **Locum Tenens/Reciprocal Billing**. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)

13. **Medical Assistance**. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

14. **Medicaid**. Idaho's Medical Assistance Program. (3-30-07)

15. **Medicaid-Related Ancillary Costs**. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)

16. **Medical Necessity (Medically Necessary)**. A service is medically necessary if: (3-30-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. (3-30-07)

c. Medical services must be: (3-20-20)

i. Of a quality that meets professionally-recognized standards of health care; and (3-20-20)

ii. Substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-20-20)

17. **Medical Supplies**. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)

18. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication that is incorporated by reference in Section 004 of these rules and contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. (7-1-17)

19. Midwife. An individual qualified as one (1) of the following: (3-29-12)

a. Licensed Midwife. A person who is licensed by the Idaho Board of Midwifery under Title 54, Chapter 55, Idaho Code, and IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

b. Nurse Midwife (NM). An advanced practice registered nurse who is licensed by the Idaho Board of Nursing and who meets all the applicable requirements to practice as a nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-12)

20. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

21. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

22. Non-Physician Practitioner (NPP). A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), pharmacist (RPh), and physician assistants (PA), as defined in these rules. (3-20-20)

23. Nurse Practitioner (NP). A registered nurse or 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." (7-1-13)

24. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

25. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-30-07)

26. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-30-07)

27. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

28. Oxygen-Related Equipment. Equipment that is utilized or acquired for the routine administration of oxygen in any setting in which normal life activities take place. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment that is used solely for the administration of medication into the lungs is excluded from this definition. (7-1-17)

012. DEFINITIONS: P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-30-07)

02. Patient. The person undergoing treatment or receiving services from a provider. (3-30-07)

03. **Pharmacist**. A person who meets all the applicable requirements to practice as licensed pharmacist under Title 54, Chapter 17, Idaho Code, and IDAPA 27.01.01, "Rules for the Idaho State Board of Pharmacy." (3-20-20)

04. **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. (3-30-07)

05. **Physician Assistant (PA)**. 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." (3-30-07)

06. **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. (3-30-07)

07. **Prepaid Ambulatory Health Plan (PAHP)**. As defined in 42 CFR 438.2, a PAHP is an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. (3-20-14)

08. **Private Rate**. Rate most frequently charged to private patients for a service or item. (3-30-07)

09. **PRM**. Provider Reimbursement Manual. (3-30-07)

10. **Prosthetic Device**. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of their practice as defined by state law to: (3-30-07)

a. Artificially replace a missing portion of the body; or (3-30-07)

b. Prevent or correct physical deformities or malfunctions; or (3-30-07)

c. Support a weak or deformed portion of the body. (3-30-07)

d. Computerized communication devices are not included in this definition of a prosthetic device. (3-30-07)

11. **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 who has entered into a written provider agreement with the Department in accordance with Section 205 of these rules. (3-30-07)

12. **Provider Agreement**. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. (3-30-07)

13. **Provider Reimbursement Manual (PRM)**. A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. (3-30-07)

14. **Prudent Layperson**. A person who possesses an average knowledge of health and medicine. (3-30-07)

15. **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." (3-30-07)

16. **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. (3-30-07)

17. **Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

18. **Quality Improvement Organization (QIO)**. An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (3-30-07)

19. **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 the services, facilities, or supplies for the provider. (3-30-07)

20. **R.N**. Registered Nurse, which in the State of Idaho is known as a Licensed Registered Nurse, is a person who meets all the applicable requirements and is licensed to practice as a Licensed Registered Nurse under Sections 54-1401 through 54-1418, Idaho Code.. (3-30-07)

21. **Rural Health Clinic (RHC)**. An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. (3-30-07)

22. **Rural Hospital-Based Nursing Facilities**. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (3-30-07)

23. **Social Security Act**. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-30-07)

24. **State Plan**. The contract between the state and federal government under 42 USC Section 1396a(a). (3-30-07)

25. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-30-07)

26. **Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-30-07)

27. **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. (3-30-07)

28. **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. (3-30-07)

29. **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 medical assistance participant. (3-30-07)

30. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-07)

013. MEDICAL CARE ADVISORY COMMITTEE.
The Director of the Department will appoint a Medical Care Advisory Committee to advise and counsel on all aspects of health and medical services. (3-30-07)

01. **Membership**. The Medical Care Advisory Committee will include, but not be limited to, the following: (3-30-07)

a. Licensed physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; and (3-30-07)

b. Members of consumer groups, including medical assistance participants and consumer organizations. (3-30-07)

02. **Organization**. The Medical Care Advisory Committee will: (3-30-07)

a. Consist of not more than twenty-two (22) members; and (3-30-07)

b. Be appointed by the Director to the Medical Care Advisory Committee to serve three (3) year terms, whose terms are to overlap; and (3-30-07)

c. Elect a chairman and a vice-chairman to serve a two (2) year term; and (3-30-07)

d. Meet at least quarterly; and (3-30-07)

e. Submit a report of its activities and recommendations to the Director at least once each year. (3-30-07)

03. **Policy Function**. The Medical Care Advisory Committee must be given opportunity to participate in medical assistance policy development and program administration. (3-30-07)

04. **Staff Assistance**. The Medical Care Advisory Committee must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. (3-30-07)

014. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

100. ELIGIBILITY FOR MEDICAL ASSISTANCE.
Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Eligibility for the Aged, Blind and Disabled (AABD)," are applicable in determining eligibility for medical assistance. (3-30-07)

101. -- 124. (RESERVED)

125. MEDICAL ASSISTANCE PROCEDURES.

01. **Issuance of Identification Cards**. When a person is determined eligible for medical assistance, the Department will issue a Medicaid identification card to the participant. When requested, the Department will give providers of medical services eligibility information regarding participants so that services may be provided. (3-30-07)

02. **Identification Card Information**. An identification card will be issued to each participant and will contain the following information: (3-30-07)

a. The name of the participant to whom the card was issued; and (3-30-07)

b. The participant's Medicaid identification number; and (3-30-07)

c. The card number. (3-30-07)

03. Information Available for Participants. The following information will be available at each Field Office for use by each medical assistance participant: (3-30-07)

a. The amount, duration and scope of the available care and services; and (3-30-07)

b. The manner in which the care and services may be secured; and (3-30-07)

c. How to use the identification card. (3-30-07)

126. -- 149. (RESERVED)

150. CHOICE OF PROVIDERS.

01. Service Selection. Each participant may obtain any services available from any participating institution, agency, pharmacy, or practitioner of their choice, unless enrolled in Healthy Connections or a Prepaid Ambulatory Health Plan (PAHP) that limits provider choice. This, however, does not prohibit the Department from establishing the fees that will be paid to providers for furnishing medical and remedial care available under the Medical Assistance Program, or from setting standards relating to the qualifications of providers of such care. (3-20-14)

02. Lock-In Option. (3-30-07)

a. The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules. (3-30-07)

b. In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of their choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (3-30-07)

151. -- 159. (RESERVED)

160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.
The participant is solely responsible for making and keeping an appointment with the provider. The Department will not reimburse providers when participants do not attend scheduled appointments. Providers may not bill participants for missed appointments. (3-20-14)

161. -- 164. (RESERVED)

165. COST-SHARING.

01. Co-Payments. When a participant accesses certain services inappropriately, the provider can require the participant to pay a co-payment as described in IDAPA 16.03.18, “Medicaid Cost-Sharing.” (4-2-08)

02. Premiums. A participant can be required to share in the cost of basic plan benefits in the form of a premium as described in IDAPA 16.03.18, “Medicaid Cost-Sharing.” (4-2-08)

166. -- 199. (RESERVED)

GENERAL PROVIDER PROVISIONS
(Sections 200-299)

200. PROVIDER APPLICATION PROCESS.

01. Provider Application. Providers who meet Medicaid enrollment requirements may apply for Idaho Medicaid provider status with the Department. All healthcare providers who are eligible for a National

Provider Identifier (NPI) must apply using that identifying number. For providers not eligible for a NPI, the Department will assign a provider number upon approval of the application. (3-20-14)

02. Screening Levels. In accordance with 42 CFR 455.450, the Department will assign risk levels of "limited," "moderate," or "high" to defined groups of providers. These assignments and definitions will be published in the provider handbook. (3-20-14)

03. Medicare Enrollment Requirement for Specified Providers. The following providers must enroll as Medicare providers or demonstrate enrollment with another state's Medicaid agency prior to enrollment or revalidation as an Idaho Medicaid provider. (7-1-17)

a. Any providers classified in the "moderate" or "high" categorical risk level, as defined in the provider handbook. (3-20-14)

b. Any provider type classified as an institutional provider by Medicare. (3-20-14)

04. Disclosure of Information by Providers and Fiscal Agents. All enrolling providers and their fiscal agents must comply with the disclosure requirements as stated in 42 CFR 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." (3-20-14)

05. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity. Reasons for denying provider status include those described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 265. (3-20-14)

06. Mandatory Denial of Provider Agreement. The Department will deny a request for a provider agreement when: (3-20-14)

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board; (3-20-14)

b. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program, or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; (3-20-14)

c. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; (3-20-14)

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 200.06.a. through 200.06.c. of this rule. (3-20-14)

e. The provider fails to comply with any applicable requirement under 42 CFR 455. (3-20-14)

f. The provider is precluded from enrollment due to a temporary moratorium issued by the Secretary of Health and Human Services in accordance with 42 CFR 455.470. (3-20-14)

g. The provider is currently suspended from Medicare or Medicaid in any state, or has been terminated from Medicare or Medicaid in any state. (3-20-14)

201. -- 204. (RESERVED)

205. AGREEMENTS WITH PROVIDERS.

01. In General. All individuals or organizations must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by the provider or by an owner or officer who has the legal authority to bind the provider in the agreement. (3-20-14)

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: (3-30-07)

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (3-30-07)

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (3-30-07)

03. Provider Agreement Enforcement Actions and Terminations. Provider agreements may be terminated with or without cause. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." The Department may, at its discretion, take any of the following actions for cause based on the provider's conduct or the conduct of its employees or agents, or when the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation: (3-20-14)

a. Require corrective actions as described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 270. (3-20-14)

b. Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement; (3-20-14)

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (3-20-14)

d. Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or (3-20-14)

e. Terminate the provider's agreement. (3-20-14)

04. Termination of Provider Agreements. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, the period is twenty-eight (28) days. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. (3-20-20)

206. -- 209. (RESERVED)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. (3-20-14)

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-20-14)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-07)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for an electronic mail message (e-mail), or facsimile transmission (fax). (3-13-20)T

211. -- 214. (RESERVED)

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. (3-30-07)

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (3-30-07)

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. (3-30-07)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions provided in Subsection 215.05 of this rule. (3-25-16)

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and (3-30-07)

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. (3-30-07)

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the following exceptions: (3-25-16)

a. When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be paid and the resources billed by the Department; (3-25-16)

b. Preventive pediatric care including early and periodic screening and diagnosis. Screening and diagnosis program services include: (7-1-19)

i. Regularly scheduled examinations and evaluations of the general physical, dental, and mental health, growth, development, and nutritional status of children under age twenty-one (21), provided according to guidance for child wellness exams published in the Medicaid General Provider and Participant Handbook; (3-25-16)

ii. Immunizations recommended by the American Academy of Pediatrics immunization schedule; (3-25-16)

iii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. (3-25-16)

c. When prior authorization has been approved according to Section 883 of these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; (3-25-16)

d. If the claim is for preventative pediatric care as described in Subsection 215.05.b of this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party according to 42 U.S.C. 1396a(a)(25)(E). (7-1-19)

06. Accident Determination. When the participant's Medicaid card indicates private insurance or when the diagnosis indicates an accident for which private insurance is often carried, or both, the claim will be suspended or denied until it can be determined that there is no other source of payment. (3-20-20)

07. Third Party Payments. The Department will pay the provider the lowest amount of the following: (3-29-12)

a. The provider's actual charge for the service; or (3-29-12)

b. The maximum allowable charge for the service as established by the Department in its pricing file. If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation; or (3-29-12)

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. (3-29-12)

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (3-30-07)

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. (3-30-07)

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on their behalf. (3-30-07)

09. Subrogation of Legal Fees. (3-30-07)

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. (3-30-07)

b. If a settlement or judgment is received by the participant that does not specify which portion of the settlement or judgment is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. (3-30-07)

216. -- 224. (RESERVED)

225. REPORTING TO THE INTERNAL REVENUE SERVICE (IRS).
In accordance with 26 U.S.C 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number. (3-30-07)

226. -- 229. (RESERVED)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-30-07)

a. Each participant may consult a participating physician or provider of their choice for care and receive covered services by presenting their identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a Prepaid Ambulatory Health Plan (PAHP). (3-20-14)

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must comply with referral or follow-up communication requirements defined in Section 210 of these rules. (3-25-16)

c. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department. (3-30-07)

d. The Department is to process each claim received and make payment directly to the provider. (3-30-07)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. (3-30-07)

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-30-07)

a. The provider's actual charge for service; or (3-30-07)

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 (3-30-07)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-30-07)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-30-07)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services that are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. (3-30-07)

05. Review of Records. (3-30-07)

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review pertinent records of providers receiving Medicaid reimbursement for covered services. (3-30-07)

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-30-07)

i. The necessity for the care; or (3-30-07)

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (3-30-07)

iii. That charges were not in excess of the provider's usual and customary rates; or (3-30-07)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-30-07)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-30-07)

i. Withholding payments to the provider until access to the requested information is granted; or (3-30-07)

ii. Suspending the provider's number. (3-30-07)

06. 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 that furnish services free of charge, or at a nominal charge, are reimbursed fair compensation that is the same as reasonable cost. (3-30-07)

07. Procedures for Medicare Cross-Over Claims. (3-30-07)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-30-07)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information on the computer tape that is received from the Medicare Part B Carrier on a weekly basis. (3-30-07)

c. If a provider does not accept a Medicare assignment, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

d. For all other services, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-30-07)

231. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS. The provisions in Subsections 231.01 and 231.02 of this rule apply only to hospitals, FQHCs, RHCs and Home Health providers. (3-30-07)

01. Interest Charges on Overpayments and Underpayments. The Medicaid program will charge interest on overpayments, and pay interest on underpayments, as follows: (3-30-07)

a. 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 the Department reimbursement notice, interest will accrue from the date of receipt of the Department reimbursement notice, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day 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. (3-30-07)

b. 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. (3-30-07)

c. 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. (3-30-07)

d. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes that occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. (3-30-07)

02. Recovery Methods for Overpayments. One (1) of the following methods will be used for recovery of overpayments: (3-30-07)

a. 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. (3-30-07)

b. Periodic Voluntary Repayment. The provider must: (3-20-20)

i. Request in writing that recovery of the overpayment be made over a period of twelve (12) months or less; and (3-20-20)

ii. 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. (3-20-20)

c. 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. (3-30-07)

d. Recovery from Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR Section 405.377. (3-30-07)

232. -- 234. (RESERVED)

235. PATIENT "ADVANCE DIRECTIVES."

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: (3-30-07)

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advance directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. (3-30-07)

i. The provider must explain that the participant has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (3-30-07)

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" or "Durable Power of Attorney For Health Care," or both. (3-20-20)

iii. The provider must comply with Subsection 235.02 of this rule. (3-30-07)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. (3-30-07)

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health Care," or both), or have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health Care," or both). (3-20-20)

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an "Advance Directive." (3-30-07)

e. If the provider cannot comply with the patient's "Living Will" or "Durable Power of Attorney for Health Care," or both, as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. (3-20-20)

f. Provide education to their staff and the community on issues concerning advance directives. (3-30-07)

02. When "Advance Directives" Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advance Directives" to adult participants in the following situations: (3-30-07)

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless Subsection 235.03 of this rule applies. (3-30-07)

b. Nursing facilities must give the information at the time of the participant's admission as a resident. (3-30-07)

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. (3-30-07)

d. The personal care R.N. supervisors will inform the participant when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the Qualified Intellectual Disabilities Professional (QIDP) and the personal care attendant of the participants decision regarding "Advance Directives." (3-30-07)

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. (3-30-07)

03. Information Concerning "Advance Directives" at the Time an Incapacitated Individual Is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once they are no longer incapacitated. (3-30-07)

04. Provider Agreement. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. (3-30-07)

236. -- 244. (RESERVED)

245. PROVIDERS OF SCHOOL-BASED SERVICES.
Only school districts and charter schools can be reimbursed for the services described in Sections 850 through 856 of these rules. (7-1-13)

246. -- 249. (RESERVED)

250. 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. (3-30-07)

251. -- 299. (RESERVED)

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS (Sections 300-389)

300. 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. (3-30-07)

301. -- 304. (RESERVED)

305. REIMBURSEMENT SYSTEM AUDITS.

01. Scope of Reimbursement System Audits. 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: (3-30-07)

a. Cost verification of actual costs for providing goods and services; (3-30-07)

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-30-07)

c. Effectiveness of the service to achieve desired results or benefits; and (3-30-07)

d. Reimbursement rates or settlement calculated under this chapter. (3-30-07)

02. 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, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-30-07)

306. -- 329. (RESERVED)

330. 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 Section 305 of these rules. (3-30-07)

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (3-30-07)

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. The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-30-07)

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (3-30-07)

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. (3-30-07)

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. (3-30-07)

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. (3-30-07)

05. Retention of Records. Records required in Subsections 330.01 through 330.03 of this rule 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. (3-30-07)

331. -- 339. (RESERVED)

340. DRAFT AUDIT REPORT.
Following completion of the audit field work 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. (3-30-07)

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: (3-30-07)

a. Requests an extension prior to the expiration of the original review period; and (3-30-07)

b. Clearly demonstrates the need for additional time to properly respond. (3-30-07)

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. (3-30-07)

341. 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 (3-30-07)

342. -- 359. (RESERVED)

360. 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. (3-30-07)

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. (3-30-07)

361. APPLICATION.

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. (3-30-07)

a. Common Ownership Rule. 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. (3-30-07)

b. Control Rule. 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 that is decisive, not its form or the mode of its exercise. (3-30-07)

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. (3-30-07)

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the Program. (3-30-07)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See Chapters 2, 10, and 12, PRM, for specifics. (3-30-07)

362. 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: (3-30-07)

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (3-30-07)

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. (3-30-07)

03. Lease or Rentals of Hospital. The exception is not applicable to sales, lease or rentals of hospitals. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished as described in Sections 1008 and 1012, PRM. (3-30-07)

a. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (3-30-07)

b. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value as described in Section 1005, PRM. (3-30-07)

363. -- 389. (RESERVED)

EXCLUDED SERVICES
(Section 390)

390. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE.
The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: (3-30-07)

01. Service Categories Not Covered. The following service categories are not covered for payment by the Medical Assistance Program: (3-30-07)

a. Acupuncture services; (3-30-07)

b. Naturopathic services; (3-30-07)

c. Bio-feedback therapy; (3-30-07)

d. Group hydrotherapy; and (3-30-07)

e. Fertility-related services, including testing. (3-30-07)

02. Types of Treatments and Procedures Not Covered. The costs of physician and hospital services for the following types of treatments and procedures are not covered for payment by the Medical Assistance Program: (3-30-07)

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (3-30-07)

b. Cosmetic surgery, excluding reconstructive surgery that has prior approval by the Department; (3-30-07)

c. Acupuncture; (3-30-07)

d. Bio-feedback therapy; (3-30-07)

e. Laetrile therapy; (3-30-07)

f. Procedures and testing for the inducement of fertility. This includes artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomies; (3-20-20)

g. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (3-30-07)

h. Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 662 of these rules; (3-30-07)

i. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; (3-30-07)

j. The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the Department; (3-30-07)

k. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (3-30-07)

l. Eye exercise therapy; or (3-30-07)

m. Surgical procedures on the cornea for myopia. (3-30-07)

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Treatments and procedures deemed experimental are not covered for payment by the Medical Assistance Program under the following circumstances: (3-30-07)

a. The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects; (3-30-07)

b. There is inadequate available clinical or pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (3-30-07)

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (3-30-07)

391. -- 398. (RESERVED)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Non-physician practitioner services are described in Sections 520 through 526. (7-1-17)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 579 of these rules**.** (5-8-09)

a. Healthy Connections services are described in Sections 560 through 566. (4-4-13)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. (3-20-20)

a. Children's habilitation intervention services are described in Sections 570 through 577. (3-20-20)

b. Child Wellness Services are described in Sections 580 through 586. (3-30-07)

c. Adult Physical Services are described in Sections 590 through 596. (3-30-07)

d. Screening mammography services are described in Sections 600 through 606. (3-30-07)

e. Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)

f. Additional Assessment and Evaluation services are described in Section 615. (4-4-13)

g. Health Questionnaire Assessment is described in Section 618. (4-4-13)

h. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

i. Nutritional services are described in Sections 630 through 636. (3-30-07)

j. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Outpatient Behavioral Health Services. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (3-20-14)

11. Inpatient Psychiatric Hospital Services. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-20-14)

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. Dental Services. The dental services covered by Medicaid are covered under a selective contract as described in Section 800 through 819 of these rules. (4-11-19)

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 857. (3-20-14)

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency medical transportation services are described in Sections 870 through 876. (4-4-13)

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

COVERED SERVICES
(Sections 400-899)

SUB AREA: HOSPITAL SERVICES
(Sections 400-449)

400. INPATIENT HOSPITAL SERVICES: DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (3-30-07)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (3-30-07)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (3-30-07)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (3-30-07)

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. (3-20-20)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Critical Access Hospitals (CAH). A rural hospital with twenty five (25) or less beds as set forth in 42 CFR Section 485.620. (4-7-11)

09. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

10. Customary Hospital Charges. Customary hospital charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. (3-29-12)

a, No more than ninety-one and seven-tenths percent (91.7%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. (3-29-12)

b. For in-state hospitals that are not specified in Section 56-1408, Idaho Code, no more than one hundred percent (100%) of covered charges will be reimbursed. (3-29-12)

c. No more than one hundred one percent (101%) of covered charges will be reimbursed to Critical Access Hospitals (CAH) for in-state hospitals. (3-29-12)

d. No more than eighty-seven and one-tenth percent (87.1%) of covered charges will be reimbursed to out-of-state hospitals. (3-29-12)

11. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (3-30-07)

12. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (3-30-07)

13. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

14. Excluded Units. Excluded units are distinct units in hospitals that are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-30-07)

15. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

16. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (3-30-07)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments' county assistance programs. (3-30-07)

17. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (3-30-07)

18. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term "inpatient days" includes administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH threshold computations. (4-7-11)

19. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (3-30-07)

20. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (3-30-07)

21. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. (3-30-07)

22. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs that are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (3-30-07)

23. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. For inpatient services on or after July 1, 2010, the principal year will be the Medicare cost report period used to prepare the Medicaid cost settlement. (3-20-20)

24. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

25. Reasonable Costs. Except as otherwise provided in Subsection 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care that a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (3-30-07)

26. Reimbursement Floor Percentage. (3-29-12)

a. The floor calculation for out-of-state hospitals is seventy-three and five-tenths percent (73.5%) of Medicaid costs. (3-29-12)

b. The floor calculation for in-state CAH hospitals is one hundred one percent (101%) of Medicaid costs. (3-29-12)

c. For in-state hospitals that are not specified in Section 56-1408, Idaho Code, the floor calculation is eighty-five percent (85%) of Medicaid costs. (3-29-12)

d. For in-state hospitals that are specified in Section 56-1408, Idaho Code, the floor calculation is seventy-seven and four-tenths percent (77.4%) of Medicaid costs. (3-29-12)

27. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. (4-7-11)

28. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

401. (RESERVED)

402. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. All hospital services must conform to federal and state laws and regulations. Services must be medically necessary as defined in Section 011 of these rules. (7-1-18)

01. Initial Length of Stay. Prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. (7-1-18)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days in excess of the initial length of stay, or previously approved extended stay. (7-1-18)

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services: (3-30-07)

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board. (3-30-07)

b. The Department will not authorize reimbursement above the all-inclusive rate unless the attending physician orders a room that is not an all-inclusive rate room for the patient because of medical necessity. (3-30-07)

403. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department or its designee. Documentation for the request must include the most recent plan of care and adequate documentation to demonstrate continued medical necessity. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. (7-1-18)

02. Certification of Need. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required, but may be required more frequently as determined by the Department. (7-1-18)

03. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days, but may be required more frequently as determined by the Department. The plan must include: (7-1-18)

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission; (7-1-18)

b. A description of the functional level of the individual; (7-1-18)

c. Any orders for medications, treatments, rehabilitative services, activities, social services, or diet; and (7-1-18)

d. Plans for continuing care or discharge, as appropriate. (7-1-18)

04. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from

the Department, or its designee. The request should be made before the initial length of stay or previously authorized extended stay ends, and submitted as designated by the Department, or its designee. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. (7-1-18)

05. Administratively Necessary Day Requests (AND). When Administratively Necessary Days are requested, the hospital must provide the Department with complete and timely documentation prior to the participant's anticipated discharge date. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing. Hospitals must make the documentation and related information requested by the Department available within ten (10) working days of the date of the request for subsequent payment to be granted. The documentation provided by the hospital will include: (3-20-20)

a. A Brief Summary. A brief summary of the participant's medical condition; and (3-30-07)

b. Statements. Statements as to why the participant is unable to discharge to a nonhospital setting; and (7-1-18)

c. Documentation. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization within twenty-five (25) miles that is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. (7-1-18)

404. INPATIENT HOSPITAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital that provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. (3-30-07)

405. INPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a hospital inflation index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the hospital inflation index. (7-1-18)

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the hospital inflation index for each subsequent fiscal year. (7-1-18)

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the hospital inflation index, will be the Medicaid cost limit for operating costs in the current year. (7-1-18)

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the hospital inflation cost index. (7-1-18)

(2) Providers will be notified of the estimated inflation index periodically or hospital inflation index (CMS Market Basket Index) prior to final settlement only upon written request. (7-1-18)

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in this rule, will be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-20-20)

b. Reimbursement to Public Hospitals. A public hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (7-1-18)

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (7-1-18)

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's case-mix index divided by the principal year's case-mix index. (7-1-18)

ii. The contested case procedure set forth in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid cost limits. (7-1-18)

d. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If a review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 402 of these rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in this rule. (7-1-18)

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-30-07)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment that would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

05. Hospital Penalty Schedule. (3-30-07)

a. A request for a preadmission or continued stay QIO review, or for both, that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. (3-20-20)

b. A request for a preadmission or continued stay QIO review, or for both, that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. (3-20-20)

c. A request for a preadmission or continued stay QIO review, or for both, that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. (3-20-20)

d. A request for a preadmission or continued stay QIO review, or for both, that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-20-20)

e. A request for a preadmission or continued stay QIO review, or for both, that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-20-20)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services that are included in the calculation of nursing facility property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital "swing-beds" who require nursing facility level of care. (4-11-19)

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 "Special Requirements" for hospital providers of long-term care services ("swing-beds"), or 42 CFR 485.645 – Special requirements for CAH providers of long-term services ("swing-beds") as applicable; and (4-11-19)

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-30-07)

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-30-07)

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services that are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety-five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles contingent on a review of medical necessity, cost-effectiveness, residency, and quality of care. (4-11-19)

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. (3-20-20)

a. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals that: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

b. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho that have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

c. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

d. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. (3-30-07)

e. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

f. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (4-7-11)

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (4-7-11)

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (4-7-11)

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (4-7-11)

(1) Recover the overpayment from the provider; and (4-7-11)

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (4-7-11)

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (4-7-11)

10. Out-of-State Hospitals. (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

11. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

12. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions,

purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

13. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

14. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

15. 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 that sets forth the amounts of underpayment or overpayment made to the provider. 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. 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. (3-30-07)

a. 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. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year 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. (3-30-07)

16. Nonappealable Items. The formula for the determination of the hospital inflation index, the principles of reimbursement that define allowable cost, non-Medicaid program issues, interim rates that are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits are not acceptable as appealable items. (7-1-18)

17. Interim Reimbursement Rates. The interim reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-20-20)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

18. **Audits**. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

406. INPATIENT HOSPITAL SERVICES: QUALITY ASSURANCE.
The designated QIO must prepare, distribute, and maintain a provider manual that is periodically updated. The manual must include the following: (3-30-07)

01. **QIO Information**. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (3-30-07)

02. **Department Provisions**. Department-selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (3-30-07)

03. **Approval Timeframe**. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. (3-30-07)

04. **Method of Notice**. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (3-30-07)

05. **Procedural Information**. The procedures that providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days." (3-30-07)

407. -- 409. (RESERVED)

410. OUTPATIENT HOSPITAL SERVICES: DEFINITIONS.
Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. (3-30-07)

411. (RESERVED)

412. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. **Services Provided On-Site**. Outpatient hospital services must be provided on-site. (3-30-07)

02. **Exceptions and Limitations**. (3-30-07)

a. Payment for emergency room service is limited to six (6) visits per calendar year. (3-30-07)

b. Emergency room services that are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. (3-30-07)

03. **Co-Payments**. (4-2-08)

a. When an emergency room physician conducts a medical screening and determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (4-2-08)

b. A hospital may refuse to provide services to a participant when a medical screening has determined that an emergency condition does not exist and the participant does not make the required co-payment at the time of service. Under these circumstances, the hospital must provide notification to the participant as specified in Section 1916A(e) of the Social Security Act. (4-2-08)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery of Outpatient Services. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. (4-4-13)

02. Follow-Up for Emergency Room Patients. Hospitals must establish procedures to refer Medicaid participants who are not enrolled in Healthy Connections to an Idaho Medicaid Healthy Connections provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Healthy Connections provider with that PCP. (3-25-16)

414. (RESERVED)

415. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (3-30-07)

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (3-30-07)

b. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (3-30-07)

c. Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (3-30-07)

d. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or (3-30-07)

ii. The blended payment amount that is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or (3-30-07)

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or (3-30-07)

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (3-30-07)

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (3-30-07)

i. The hospital's reasonable costs; or (3-30-07)

ii. The hospital's customary charges; or (3-30-07)

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (3-30-07)

02. Reduction to Outpatient Hospital Costs. Outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: (3-29-12)

a. In-state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare-designated sole community hospital or rural primary care hospital. (3-29-12)

b. Out-of-state hospitals that are not a Medicare-designated sole community hospital or rural primary care hospital. (3-29-12)

416. -- 421. (RESERVED)

422. RECONSTRUCTIVE SURGERY: COVERAGE AND LIMITATIONS.
Reconstruction or restorative procedures that may be rendered with prior approval by the Department include procedures that restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. (3-30-07)

423. -- 430. (RESERVED)

431. SURGICAL PROCEDURES FOR WEIGHT LOSS: PARTICIPANT ELIGIBILITY.
Surgery for the correction of obesity is covered when all of the following conditions are met: (3-30-07)

01. Participant Medical Condition. The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery. (3-30-07)

02. Other Medical Condition Exists. The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease. (3-30-07)

03. Psychiatric Evaluation. The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the date a request for prior authorization is submitted to Medicaid. (3-30-07)

432. SURGICAL PROCEDURES FOR WEIGHT LOSS: COVERAGE AND LIMITATIONS.

01. Non-Surgical Treatment for Obesity. Services in connection with non-surgical treatment of obesity are covered only when such services are an integral and necessary part of treatment for another medical condition that is covered by Medicaid. (3-30-07)

02. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered when medically necessary, as defined in Section 011 of these rules, and when the surgery is prior authorized by the Department. The request for prior authorization must include the following documentation: (3-30-07)

a. Photographs of the front, side and underside of the participant's abdomen; (3-30-07)

b. Treatment of any ulceration and skin infections involving the panniculus; (3-30-07)

c. Failure of conservative treatment, including weight loss; (3-30-07)

d. That the panniculus severely inhibits the participant's walking; (3-30-07)

e. That the participant is unable to wear a garment to hold the panniculus up; and (3-30-07)

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (3-30-07)

433. SURGICAL PROCEDURES FOR WEIGHT LOSS: PROCEDURAL REQUIREMENTS.

01. Medically Necessary. The Department must determine the surgery to be medically necessary, as defined in Section 011 of these rules. (3-30-07)

02. Prior Authorization. The surgery must be prior authorized by the Department. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized. (3-30-07)

434. SURGICAL PROCEDURES FOR WEIGHT LOSS: PROVIDER QUALIFICATIONS AND DUTIES.
Physicians and hospitals must meet national medical standards for weight loss surgery. (3-30-07)

435. -- 442. (RESERVED)

443. INVESTIGATIONAL PROCEDURES OR TREATMENTS: PROCEDURAL REQUIREMENTS.
The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost-benefit analysis on the procedure or treatment in question. The Department will determine coverage based on this review and analysis. (3-30-07)

01. Focused Case Review. A focused case review consists of assessment of the following: (3-30-07)

a. Health benefit to the participant of the proposed procedure or treatment; (3-30-07)

b. Risk to the participant associated with the proposed procedure or treatment; (3-30-07)

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; (3-30-07)

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; (3-30-07)

e. Phase of the clinical trial of the proposed procedure or treatment; (3-30-07)

f. Guidance regarding the proposed procedure or treatment by national organizations; (3-30-07)

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (3-30-07)

h. Ethics Committee review, if appropriate. (3-30-07)

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (3-30-07)

03. Cost-Benefit Analysis. The Department will perform a cost-benefit analysis that will include at least the following: (3-30-07)

a. Estimated costs of the procedure or treatment in question. (3-30-07)

b. Estimated long-term medical costs if this procedure or treatment is allowed. (3-30-07)

c. Estimated long-term medical costs if this procedure is not allowed. (3-30-07)

d. Potential long-term impacts approval of this procedure or treatment may have on the Medical Assistance Program. (3-30-07)

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost-benefit analysis, and any additional information received during the review process. (3-30-07)

444. -- 449. (RESERVED)

SUB AREA: AMBULATORY SURGICAL CENTERS
(Sections 450-499)

450. -- 451. (RESERVED)

452. AMBULATORY SURGICAL CENTER SERVICES: COVERAGE AND LIMITATIONS.
Those surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, the Department may add surgical procedures to the list developed by the Medicare program as required by 42 CFR 416.164 if the procedures meet the criteria identified in 42 CFR 416.166. (3-30-07)

453. RESERVED

454. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Approval. The ASC must be surveyed by the Department's Bureau of Facility Standards as required by 42 CFR 416.25 through 416.52 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. (3-30-07)

02. Cancellation. Grounds for cancellation of the provider agreement include: (3-30-07)

a. The loss of Medicare program approval; (3-30-07)

b. Identification of any condition that threatens the health or safety of patients by the Department's Bureau of Facility Standards. (3-30-07)

455. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and

supplies necessary to safely care for the patient. Such services are reimbursed as follows: (3-30-07)

a. ASC service payments represent reimbursement for the costs of goods and services recognized by the Medicare program as described in 42 CFR, Part 416. Payment levels will be determined by the Department. Any surgical procedure covered by the Department, but which is not covered by Medicare will have a reimbursement rate established by the Department. (3-30-07)

b. ASC services include the following: (3-30-07)

i. Nursing, technician, and related services; (3-30-07)

ii. Use of ASC facilities; (3-30-07)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (3-30-07)

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (3-30-07)

v. Administration, record-keeping and housekeeping items and services; and (3-30-07)

vi. Materials for anesthesia. (3-30-07)

c. ASC services do not include the following services: (3-30-07)

i. Physician services; (3-30-07)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (3-30-07)

iii. Prosthetic and orthotic devices; (3-30-07)

iv. Ambulance services; (3-30-07)

v. Durable medical equipment typically used in the participant's place of residence, but may be suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, or ICF/ID; and (7-1-17)

vi. Any other service not specified in Subsection 455.01.b. of this rule. (3-30-07)

02. Payment for Ambulatory Surgical Center Services. Payment is made at a rate established in accordance with Section 230 of these rules. (3-30-07)

456. -- 499. (RESERVED)

SUB AREA: PHYSICIAN SERVICES AND ABORTION PROCEDURES
(Sections 500-519)

500. PHYSICIAN SERVICES.
Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Section 502 of these rules. (3-13-20)T

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Sterilization Procedures. Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (7-1-18)

02. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

03. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (7-1-18)

04. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services that are described and supported by the diagnosis. (3-30-07)

05. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

06. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

503. (RESERVED)

504. PHYSICIAN SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Misrepresentation of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. (3-30-07)

02. Locum Tenens Claims and Reciprocal Billing. (3-30-07)

a. In reimbursement for Locum Tenens/reciprocal billing, the patient's regular physician may submit the claim and receive payment for covered physician services (including emergency visits and related services) provided by a Locum Tenens physician who is not an employee of the regular physician if: (3-30-07)

i. The regular physician is unavailable to provide the visit services. (3-30-07)

ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. (3-30-07)

iii. The regular physician pays the Locum Tenens for their services on a per diem or similar fee-for-time basis. (3-30-07)

iv. The substitute physician does not provide the visit services to Medicaid patients over a continuous period of longer than ninety (90) days for Locum Tenens and over a continuous period of fourteen (14) days for reciprocal billing. (3-30-07)

v. The regular physician identifies the services as substitute physician services meeting the requirements of this rule by appending modifier-Q6 (service furnished by a Locum Tenens physician) to the procedure code or Q5 (services furnished by a substitute physician under reciprocal billing arrangements). (3-30-07)

vi. The regular physician must keep on file a record of each service provided by the substitute physician associated with the substitute physician's UPIN, and make this record available to the department upon request. (3-30-07)

vii. The claim identifies, in a manner specified by the Department, the physician who furnished the services. (3-30-07)

b. If the only Locum Tenens/reciprocal billing services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services may not be reported separately on the claim as substitution services, but must be deemed as included in the global fee payment. (3-30-07)

c. A physician may have Locum Tenens/reciprocal billing arrangements with more than one (1) physician. The arrangements need not be in writing. Locum Tenens/reciprocal billing services need not be provided in the office of the regular physician. (3-30-07)

505. PHYSICIAN SERVICES: PROVIDER REIMBURSEMENT.

01. Physician Penalties for Late QIO Review. Medicaid will assess the physician a penalty for failure to request a preadmission review from the Department, for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual. If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review the Department will assess a penalty according to Subsection 505.02 of this rule. The penalty will be assessed after payment for physician services has occurred. (3-30-07)

02. Physician Penalty Schedule. (3-30-07)

a. A request for preadmission QIO review that is one (1) day late will result in a penalty of fifty dollars ($50). (3-30-07)

b. A request for preadmission QIO review that is two (2) days late will result in a penalty of one hundred dollars ($100). (3-30-07)

c. A request for preadmission QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars ($150). (3-30-07)

d. A request for preadmission QIO review that is four (4) days late will result in a penalty of two hundred dollars ($200). (3-30-07)

e. A request for preadmission QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars ($250). (3-30-07)

03. Physician Excluded From the Penalty. Any physician who provides care but has no control over the admission, continued stay, or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. (3-30-07)

506. -- 510. (RESERVED)

511. ABORTION PROCEDURES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions under the Medical Assistance Program only under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency. (3-30-07)

512. -- 513. (RESERVED)

514. ABORTION PROCEDURES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Required Documentation in the Case of Rape or Incest. In the case of rape or incest, the following documentation must be provided to the Department: (3-30-07)

a. A copy of the court determination of rape or incest; or (3-20-20)

b. Where no court determination has been made, documentation that the rape or incest was reported to

a law enforcement agency. (3-30-07)

c. Where the rape or incest was not reported to a law enforcement agency, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman. (3-30-07)

02. Required Documentation in the Case Where the Abortion is Necessary to Save the Life of the Woman. In the case where the abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. (3-30-07)

515. -- 519. (RESERVED)

SUB AREA: OTHER PRACTITIONER SERVICES
(Sections 520-559)

520. -- 521. (RESERVED)

522. NON-PHYSICIAN PRACTITIONER SERVICES: COVERAGE AND LIMITATIONS.
The Medicaid Program will pay for services provided by non-physician practitioners (NPPs), as defined in these rules and in accordance with the provisions found under Sections 523 through 525 of these rules. (3-20-20)

523. (RESERVED)

524. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Identification of Services. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the NPP. (3-20-20)

02. Deliverance of Services. The services must be delivered under physician supervision, if required by Idaho Statute. (3-30-07)

525. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER REIMBURSEMENT.

01. Billing of Services. Billing for the services must be as provided by the NPP and not represented as a physician service. (3-20-20)

02. Payments Made Directly to CRNA. Payments under the fee schedule must be made directly to the CRNA under the individual provider number assigned to the CRNA. Rural hospitals that qualify for a Medicare exception and employ or contract CRNAs may be reimbursed on a reasonable cost basis. (3-30-07)

03. Reimbursement Limits. The Department will reimburse for each service to be delivered by the NP, NM, CNS, or PA as either the billed charge or reimbursement limit established by the Department, whichever is less. (7-1-17)

526. -- 529. (RESERVED)

530. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. (3-30-07)

531. (RESERVED)

532. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. The Department will pay for a total of six (6) manipulation visits during any calendar year for remedial care by a chiropractor. (3-29-12)

533. (RESERVED)

534. CHIROPRACTIC SERVICES: PROVIDER QUALIFICATIONS.
A person who is qualified to provide chiropractic services is licensed by the Board of Chiropractic Physicians in the Idaho Board of Occupational Licensing, or is licensed according to the regulations in the state where the services are provided. (3-29-12)

535. -- 539. (RESERVED)

540. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. (3-29-12)

02. Chronic Foot Diseases. Chronic foot diseases, for the purpose of this provision, include: (3-29-12)

a. Diabetes melitus; (3-29-12)

b. Peripheral neuropathy involving the feet; (3-29-12)

c. Chronic thrombophlebitis; and (3-29-12)

d. Peripheral vascular disease; (3-29-12)

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or (3-29-12)

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. (3-29-12)

541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are: (3-29-12)

01. Participants Who Have a Chronic Disease. Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care. (3-29-12)

02. Participants with an Acute Condition. Participants with an acute condition that, if left untreated, may cause an adverse outcome to the participant's health. (3-29-12)

542. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to: (3-29-12)

01. Services Defined in Chronic Care Guidelines. Acute and preventive foot care services defined in chronic care guidelines; and (3-29-12)

02. Treatment of Acute Conditions. Treatment of acute conditions that if left untreated will result in chronic damage to the participant's foot. (3-29-12)

543. (RESERVED)

544. PODIATRIST SERVICES: PROVIDER QUALIFICATIONS.
A qualified podiatrist is licensed by the Board of Podiatry in the Idaho Board of Occupational Licensing, or licensed according to the regulations in the state where the services are provided. (3-29-12)

545. (RESERVED)

546. LICENSED MIDWIFE (LM) SERVICES.
The Department will reimburse licensed midwives for maternal and newborn services performed within the scope of their practice. This section of rule does not include non-physician practitioner services provided by a nurse midwife (NM) which are described in Sections 522 through 525 of these rules. (7-1-17)

547. LM SERVICES: DEFINITIONS.

01. Licensed Midwife. An individual who holds a current license issued by the Idaho Board of Midwifery. (3-29-12)

02. Board of Midwifery. The Idaho Board of Midwifery is located within the Idaho Bureau of Occupational Licensing and is the licensing authority for LM providers. (3-29-12)

548. LM SERVICES: PARTICIPANT ELIGIBILITY.
A participant is eligible for LM services if the participant is pregnant, in the six (6) week postpartum period, or is a newborn up to six (6) weeks old. (3-29-12)

549. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. (3-29-12)

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered when provided by a CPM. (3-29-12)

03. Medication - Coverage and Limitations. LM providers may administer medication and bill Medicaid if the medication is a Medicaid covered service, and is also listed in the LM formulary in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

550. LM SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each LM provider must: (3-29-12)

01. Licensed. Have a current license as a LM from the Idaho Board of Midwifery or be licensed according to the regulations in the state where the services are provided. (3-29-12)

02. Scope of Practice. Provide only those services that are within the scope of practice under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

551. LM SERVICES: PROVIDER REIMBURSEMENT.
Reimbursement for LM services will be the lesser of the billed amount, or eighty-five percent (85%) of the Department's physician fee schedule, The physician fee schedule is available from the Central Office for the Division of Medicaid, see online at: http://www.idmedicaid.com. (3-29-12)

552. LM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.
Each LM provider must: (3-20-20)

01. Licensure Required. Maintain current licensure with the Idaho Board of Midwifery. (3-29-12)

02. Informed Consent Form Required. Keep a signed copy of the participant's informed consent in the participant's record. (3-20-20)

03. Compliance with Board of Midwifery Requirements. Adhere to all regulations listed in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-20-20)

04. Department Access to Practice Data. Make all practice data submitted to the Board of Midwifery according to the provisions in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery," immediately available to the Department upon request. (3-20-20)

553. (RESERVED)

554. OPTOMETRIST SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 205 of these rules. (3-30-07)

01. Payment Availability. Payment for services included in Subsection 502.04 and Sections 780 through 786 of these rules is available to all licensed optometrists. (3-30-07)

02. Provider Agreement Qualifications. Optometrists who have been issued and who maintain certification under the provisions of Sections 54-1501 and 54-1509, Idaho Code, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules. (3-30-07)

555. -- 559. (RESERVED)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560-579)

560. HEALTHY CONNECTIONS: DEFINITIONS.
Healthy Connections is a primary care case management program in which a primary care provider or team provides comprehensive medical care for participants with the goal of improving health outcomes. For purposes of this Sub Area that includes Sections 560 through 566 of these rules, the following terms and definitions apply: (3-25-16)

01. Capitated Payments. Payments to a primary care provider made on a per assigned participant per month basis for patient services. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide as described in Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full-risk reimbursement is agreed to by the provider and the Department. (3-25-16)

02. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)

03. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)

04. Patient-Centered Medical Home. A model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. This results in primary care being delivered at the right place, at the right time, and in the manner that best suits a patient's needs. (3-25-16)

05. Preventive Care. Medical care that focuses on disease prevention and health maintenance. (4-4-13)

06. Primary Care Case Management. A model of care in which primary care providers and their primary care team are responsible for direct care of a participant, and for coordinating access to services that improve the health of the participant. (3-25-16)

07. Primary Care Provider (PCP). A physician, physician assistant, or advanced practice registered nurse as defined in IDAPA 23.01.01,"Rules of the Idaho Board of Nursing," who contracts with Medicaid to coordinate and manage the care of participants enrolled in the Healthy Connections program. (3-25-16)

08. Primary Care Team. A multidisciplinary team of health care providers who work together to meet the physical, emotional, and psychological needs of their patients using a patient-centered and coordinated approach. (3-25-16)

09. Referral. A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing specific covered services subject to primary care case management that are not provided by the participant's PCP. (4-4-13)

10. Transitional Care. A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. (3-25-16)

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

01. Primary Care Case Management Enrollment. Each participant in Idaho Medicaid is enrolled in Healthy Connections, unless the participant is granted an exemption by the Department described in Subsections 561.02.a. through 561.02.h. of this rule. Each participant must choose a PCP within the Healthy Connections program. If a participant fails to choose a PCP, one will be assigned to the participant by the Department. Participants of the same family may choose different Healthy Connections providers. (4-4-13)

02. Exemption from Participation. An exemption from participation in Healthy Connections may be granted on a individual basis by the Department for a participant who: (4-4-13)

a. Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; (4-4-13)

b. Has an eligibility period that is less than three (3) months; (4-4-13)

c. Has an eligibility period that is only retroactive; (4-4-13)

d. Is eligible only as a Qualified Medicare Beneficiary; (4-4-13)

e. Has an existing relationship with a primary care physician or clinic who is not participating in Healthy Connections; (4-4-13)

f. Is enrolled in the Medicare/Medicaid Coordinated Plan; (4-4-13)

g. Resides in a nursing facility or an ICF/ID; or (4-4-13)

h. Resides in a county where there are not an adequate number of providers to deliver primary care case management services. (4-4-13)

562. HEALTHY CONNECTIONS: PRIMARY CARE SERVICES.

01. Eligible Services. Participants enrolled with a primary care provider (PCP) are eligible to receive: (3-25-16)

a. Basic care management and care coordination; (3-25-16)

b. Timely access to routine primary care; (3-25-16)

c. A patient-centered health care decision making process; (3-25-16)

d. Twenty-four (24) hour, seven (7) days per week access to an on-call medical professional; and (3-25-16)

e. Referral to other medically necessary services as specified in Section 210 of these rules, based on the clinical judgment of their primary care provider. (3-25-16)

02. Selection or Change in Primary Care Provider. Participants may select or change their primary care provider as follows: (7-1-19)

a. When they become eligible for Idaho Medicaid benefits, or after a break in their eligibility for Idaho Medicaid benefits; (7-1-19)

b. For cause at any time ("for cause" reasons are listed in the Idaho Medicaid Provider Handbook). (7-1-19)

c. Without cause: (7-1-19)

i. During the ninety (90) days following the effective date of the participants enrollment with a PCP. (7-1-19)

ii. At least once every twelve (12) months thereafter during the open enrollment period. (7-1-19)

d. All approved PCP change requests will be effective the first of the following month. (7-1-19)

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Changes to Requirements. The Department will provide sixty (60) day notice of any substantive and significant changes to requirements for referrals, primary care provider reimbursement, as specified in Section 565 of these rules, or provider duties on its website and provider portal. The Department will provide a method to allow providers to provide input and comment on proposed changes. (3-25-16)

02. Problem Resolution. (3-30-07)

a. To help assure the success of Healthy Connections, the Department provides a mechanism for timely and personal attention to problems and complaints related to the program. (4-4-13)

b. To facilitate problem resolution, the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (4-4-13)

c. A participant or a provider may register a complaint or notify the Department of a problem related to Healthy Connections either in writing, electronically, or by telephone to the designated representative. The designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (4-4-13)

d. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the designated representative, they may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (4-4-13)

e. Decisions in response to grievances may be appealed. Appeals are governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed according to the provisions of that chapter. (4-4-13)

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary Care Providers. Primary care services may be provided by enrolled physicians, physician assistants, advanced practice registered nurses, and by care teams under those providers' direction. (3-25-16)

02. Provider Duties. All Healthy Connections providers are responsible for delivering the services listed in Section 562 of these rules. (3-25-16)

03. Additional Services. Healthy Connections providers may also elect to provide specific additional

sets of patient-centered medical home services in exchange for increased reimbursement as described in Section 565 of these rules. The definition and provision of additional patient-centered medical home services are subject to specific requirements as defined by the Department and described in the Idaho Medicaid Provider Handbook and individual provider agreements with the Department. Additional services may include: (3-25-16)

a. Connection to the Idaho Health Data Exchange; (3-25-16)

b. Maintaining third-party patient-centered medical home recognition or certification; (3-25-16)

c. Expanded patient access to services; (3-25-16)

d. Provision of an evidence-based primary care service model that enables improved patient health outcomes; (3-25-16)

e. Reporting clinical data to the Department to allow for assessment of provider abilities and impact of their services on patient health outcomes; (3-25-16)

f. Coordination of transitions of care between health care settings; (3-25-16)

g. Integration of behavioral health services; and (3-25-16)

h, Other indicators of improved patient health outcomes associated with primary care provider abilities. (3-25-16)

04. Provider Participation Conditions and Restrictions. (3-30-07)

a. Provider Agreements. Each independent provider or provider organization participating in primary care case management must: (4-4-13)

i. Sign an agreement; (4-4-13)

ii. Enroll with the Department all primary care providers and all clinic locations participating in the Healthy Connections program; and (4-4-13)

iii. Complete pre-enrollment requirements for participation in the Healthy Connections program as defined by the Department in the Idaho Medicaid Provider Handbook. (3-25-16)

b. Patient Limits. A provider may limit the number of participants they manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A provider may change the participant limit effective the first day of any month. The provider must make the request in writing to the Department thirty (30) days prior to the effective date of the change. (3-25-16)

c. Disenrollment. When the provider-patient relationship breaks down due to failure of the participant to follow the care plan or for other reasons, a provider may choose to withdraw as the participant's primary care provider effective the first day of any month. The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (4-4-13)

d. Record Retention. Each provider must: (4-4-13)

i. Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service; (4-4-13)

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP; and (4-4-13)

iii. Disclose information required by Subsection 205.01 of these rules, when applicable. (4-4-13)

e. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Capitated Payments. Healthy Connections providers are compensated for their patient care services on a per participant per month basis. (3-25-16)

02. Capitated Payment Amounts. Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of each month. (3-25-16)

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the primary care case management programs. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. (4-4-13)

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 570-649)

570. CHILDREN'S HABILITATION INTERVENTION SERVICES (CHIS).
CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid-eligible participants with identified developmental limitations that impact the participant's functional skills and behaviors across an array of developmental domains. Case Management is an available option to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. (3-20-20)

571. CHIS: DEFINITIONS.

01. Annual. Every three hundred sixty-five (365), days except during a leap year which equals three hundred sixty-six (366) days. (3-20-20)

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behavior. The stimuli usually cannot be avoided, is pain inducing, or both. (3-20-20)

03. Community. Natural, integrated environments outside the participant’s home, outside of DDA center-based settings, or at school outside of school hours. (3-20-20)

04. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (3-20-20)

a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; (3-20-20)

b. Certified by the Department to provide services to participants with developmental disabilities; and (3-20-20)

c. A business entity, open for business to the general public. (3-20-20)

05. Duplication of Services. Services are considered duplicate when: (3-20-20)

a. Goals are not separate and unique to each service provided; or (3-20-20)

b. When more than one (1) service is provided at the same time, unless otherwise authorized. (3-20-20)

06. Educational Services. Services that are provided in buildings, rooms or areas designated or used as a school or as educational facilities; that are provided during 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 that are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related service; and such services are provided to school age individuals defined in Section 33-201, Idaho Code. (3-20-20)

07. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. (3-20-20)

08. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an evidence-based model. (3-20-20)

09. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, and psychology or other areas of academic study as referenced in the Medicaid Provider Handbook. (3-20-20)

10. Practitioner of the Healing Arts, Licensed. Advanced practice registered nurse, nurse practitioner, or physician assistant. (3-20-20)

11. Recreational Services. Activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (3-20-20)

12. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. (3-20-20)

13. Treatment Fidelity. The consistent and accurate implementation of children's habilitation services accordance with the modality, manual, protocol or model. (3-20-20)

14. Vocational Services. Services or programs that 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 workforce within one (1) year. (3-20-20)

572. CHIS: ELIGIBILITY REQUIREMENTS.

01. Medicaid Eligibility. Participants must be eligible for Medicaid and the service for which the CHIS provider is seeking reimbursement. (3-20-20)

02. Age of Participants. CHIS are available to participants from birth through the month of their twenty-first birthday. (3-20-20)

03. Eligibility Determination. Participants eligible to receive CHIS must have a demonstrated functional need or a combination of functional and behavioral needs that require intervention services; or requires intervention to correct or ameliorate their condition in accordance with Section 880 of these rules. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity

for independent living, economic self-sufficiency, or maladaptive behavior. A deficit is defined as one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. (3-20-20)

573. CHIS: COVERAGE AND LIMITATIONS.

01. Excluded for Medicaid Payment. The following are excluded for Medicaid payment: (3-20-20)

i. Vocational services; (3-20-20)

ii. Educational services; and (3-20-20)

iii. Recreational services. (3-20-20)

02. Service Delivery. The CHIS allowed under the Medicaid state plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant. CHIS may be delivered in the community, the participant's home, or in a DDA in accordance with the requirements of this chapter. Duplication of services is not reimbursable. (3-20-20)

03. Required Recommendation. CHIS must be recommended by a physician or other practitioner of the healing arts within his or her scope of practice, under state law. (3-20-20)

a. The CHIS provider may not seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated recommendation. (3-20-20)

b. The recommendation is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, then and new recommendation must be received. (3-20-20)

04. Required Screening. Needs are determined through the current version of the Vineland Adaptive Behavior Scales or other Department-approved screening tools that are conducted by the family's chosen CHIS provider, the Department, or its designee, and are administered in accordance with the protocol of the tool. The screening tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: (3-20-20)

a. If a screening tool has been completed by the Department, or its designee, a new screening is not required. (3-20-20)

b. If the participant has been determined eligible by the Department, a new screening tool is not required. (3-20-20)

c. The screening cannot be billed more than once unless an additional screening is required in accordance with guidelines as outlined in the Medicaid Provider Handbook. (3-20-20)

05. Services. All CHIS recommended on a participant's assessment and clinical treatment plan must be prior authorized by the Department, or its contractor. The following CHIS are available for eligible participants and are reimbursable services when provided in accordance with these rules: (3-20-20)

a. Habilitative Skill Building. This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) participants. (3-13-20)T

ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted accordingly. (3-13-20)T

iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. (3-20-20)

b. Behavioral Intervention. This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) participants. (3-13-20)T

ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted accordingly. (3-13-20)T

iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction. (3-20-20)

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional. (3-20-20)

d. Crisis Intervention. This service may include providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis typically not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: (3-20-20)

i. Hospitalization; (3-20-20)

ii. Out of home placement; (3-20-20)

iii. Incarceration; or (3-20-20)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-20-20)

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian. The ACTP must be completed on a Department approved

form as referenced in the Medicaid Provider Handbook and contain the following minimum standards: (3-20-20)

i. Clinical interview(s) must be completed with the parent or legal guardian; (3-20-20)

ii. Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department. The most current version of the assessment must be used; (3-13-20)T

iii. Review of assessments, reports, and relevant history; (3-20-20)

iv. A reinforcement inventory or preference assessment; (3-20-20)

v. A transition plan; and (3-20-20)

vi. Be signed by the individual completing the assessment and the parent or legal guardian. (3-20-20)

574. CHIS: PROCEDURAL REQUIREMENTS.
All CHIS identified on a participant's ACTP must be prior authorized by the Department, or its contractor, and must be maintained in each participant's file. The CHIS provider is responsible for documenting and submitting the participant's ACTP to obtain prior authorization before delivering any CHIS. (3-20-20)

01. Prior Authorization Request. The request must be submitted to the Department, or its contractor, who will review and approve or deny prior authorization requests and notify the provider and the parent or legal guardian of the decision. Prior authorization is intended to help ensure the provision of medically necessary services and will be approved according to the timeframes established by the Department and as described in the Medicaid Provider Handbook. (3-20-20)

a. Once the initial request for prior authorization is submitted, CHIS may be delivered for a maximum of twenty-four (24) total hours for up to thirty (30) calendar days or until the prior authorization is approved. Initial prior authorization requests must include: (3-20-20)

i. A recommendation from a physician or other practitioner of the healing arts; (3-20-20)

ii. The ACTP; and (3-20-20)

iii. Implementation plan(s). (3-20-20)

b. Ongoing prior authorization requests must include: (3-20-20)

i. A list of the participant's objectives; (3-20-20)

ii. Graphs showing change lines; (3-20-20)

iii. A brief analysis of data regarding progress or lack of progress to meeting each objective; (3-20-20)

iv. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; (3-20-20)

v. Request for the annual ACTP, if applicable; (3-20-20)

vi. New implementation plans, if applicable; (3-20-20)

vii. An updated annual ACTP, if applicable; and (3-20-20)

viii. An annual written summary with an analysis of data regarding the participant's progress or lack of progress, justification for any changes made to implementation of programming for new objectives, discontinuation of objectives, if applicable, and a summary of parent(s) or caregiver(s) response to teaching of coordinated methods. (3-20-20)

c. The following services may be requested retroactively: (3-20-20)

i. The initial ATCP; (3-20-20)

ii. The screening tool; and (3-20-20)

iii. Crisis intervention within seventy-two (72) hours of the service initiation. (3-20-20)

02. Implementation Plan(s). An implementation plan will provide details on how intervention will be implemented and must be completed by a qualified provider. All implementation plan objectives must be related to a need identified on the ATCP. The provider must document that a copy of the participant's implementation plan(s) was offered to the participant's parent or legal guardian. The implementation plan(s) must include the following requirements: (3-20-20)

a. Participant's name; (3-20-20)

b. Measurable, behaviorally-stated objectives including criteria for successful achievement, and a baseline statement; (3-20-20)

c. Location(s) where objectives will be implemented; (3-20-20)

d. Precursor behaviors for participants receiving behavioral intervention; (3-20-20)

e. Description of the treatment modality to be utilized; (3-20-20)

f. Discriminative stimulus or direction; (3-20-20)

g. Targets, steps, task analysis or prompt level; (3-20-20)

h. Correction procedure; (3-20-20)

i. Data collection; (3-20-20)

j. Reinforcement, including type and frequency; (3-20-20)

k. A plan for generalization and a plan for family training; (3-20-20)

l. A behavior response plan for participants receiving behavioral intervention; (3-20-20)

m. Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed individual working within the scope of their practice; and (3-20-20)

n. A signature of the qualified provider who completed the document(s), date signed, and credential. (3-20-20)

03. Requirements for Program Documentation. Providers must maintain records for each participant served. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required for each visit made or service provided to the participant, including at a minimum the following information: (3-20-20)

a. Date, time, and duration; (3-20-20)

b. Summary of session or service provided, and if interdisciplinary training is provided, documentation must include who the service was delivered to and the content covered; (3-20-20)

c. Data documentation that corresponds to the implementation plans for habilitative skill building or

behavioral intervention; (3-20-20)

d. Location of service delivery; and (3-20-20)

e. Signature of the individual providing the service, date signed, and credential. (3-20-20)

04. Supervision. Supervision includes both face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Supervision is provided to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule and informs of any modification needed to the methods implemented to support the accomplishment of outcomes identified in the ACTP. Supervision must be provided in accordance with the requirements of the evidence-based model or in accordance with each individual provider qualification. Intervention specialists providing services to children birth to three (3) years old must be supervised by an intervention specialist or intervention professional who also meets the birth to three (3) years old requirements. (3-20-20)

575. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.
CHIS are delivered by individuals who meet or exceeds one (1) of the qualifying criteria below in Subsections 575.01 through 575.07 of this rule, and are employed by a certified DDA, or who meet the criteria as defined in Subsection 575.08 of this rule and is enrolled as an independent CHIS provider. All providers of CHIS must meet the continuing training requirements in Subsection 575.09 of this rule. (3-20-20)

01. Crisis Intervention Technician. A crisis intervention technician can deliver crisis intervention directly with the eligible participant and must meet the qualifications of a community- based supports staff as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 526. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur to ensure the technician demonstrates the necessary skills to correctly provide the crisis intervention service. (3-13-20)T

02. Intervention Technician. An intervention technician can deliver habilitative skill building, behavioral intervention, and crisis intervention. This is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. An intervention technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the direct services performed by the intervention technician. Supervision must occur to ensure the intervention technician demonstrates the necessary skills to correctly provide the intervention. Provisional status is limited to a single eighteen (18) successive month period. The qualifications for this type of provider can be met by one (1) of the following: (3-13-20)T

a. An individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-20-20)

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. (3-20-20)

03. Intervention Specialist. An intervention specialist can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the direct CHIS performed. Supervision must occur to ensure the intervention specialist demonstrates the necessary skills to correctly provide the service. An intervention specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. The qualifications for this type of provider can be met by one (1) of the following: (3-13-20)T

a. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, will be allowed to continue providing services as an intervention specialist as

long as there is not a gap of more than three (3) successive years of employment as an intervention specialist; or (3-20-20)

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or a has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and (3-20-20)

i. Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and (3-20-20)

ii. Meets the competency requirements by completing one (1) of the following: (3-20-20)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; or (3-20-20)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-20-20)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university internship or practicum experience and may be documented within the supervised experience listed in Subsection 575.02.b.i. of this rule, and have one (1) of the following: (3-20-20)

i. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (3-20-20)

ii. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or (3-20-20)

iii. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, counseling, or nursing. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework, or can be in addition to the degree coursework. Courses must cover the following as defined in the Medicaid Provider Handbook: (3-20-20)

(1) Promotion of development and learning for children from birth to five (5) years of age. (3-20-20)

(2) Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (3-20-20)

(3) Building family and community relationships to support early interventions; (3-20-20)

(4) Development of appropriate curriculum for young children; (3-20-20)

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (3-20-20)

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (3-20-20)

04. Intervention Professional. An intervention professional can deliver all CHIS and complete

assessments and implementation plans. Intervention professionals must meet the following minimum qualifications: (3-20-20)

a. Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-20-20)

b. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.03.c. of this rule. (3-20-20)

05. Evidence-Based Model (EBM) Intervention Paraprofessional. An EBM intervention paraprofessional can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the evidence-based model. The qualifications for this type of provider are: (3-20-20)

a. An individual who holds a high school diploma or general equivalency diploma; and (3-20-20)

b. Holds a para-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

06. Evidence-Based Model (EBM) Intervention Specialist. An EBM intervention specialist can deliver all CHIS and complete assessments and implementation plans. This individual must be supervised in accordance with the evidenced-based model and may also supervise the evidence-based paraprofessional working within the same evidence-based model. The qualifications for this type of provider are: (3-20-20)

a. An individual who holds a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)

b. Holds a bachelor-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must also have a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university activities. (3-20-20)

07. Evidence-Based Model (EBM) Intervention Professional. An EBM intervention professional can deliver all CHIS and complete assessments and implementation plans. The qualifications for this type of provider are: (3-20-20)

a. An individual who holds a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)

b. Holds a masters-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.06.c. of this rule. (3-20-20)

08. Independent CHIS Provider. This type of provider can deliver all types of CHIS, complete assessments and implementation plans in accordance with their provider qualification as defined in Subsections

575.03, 575.04, 575.06, and 575.07 of these rules. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following must be met: (3-20-20)

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (3-20-20)

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (3-20-20)

c. Compete a criminal history and background check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (3-20-20)

d. Follow all applicable requirements in Sections 570 through 577 of these rules; and (3-20-20)

e. Not receive supervision from an individual that they are directly supervising. (3-20-20)

09. Continuing Training Requirements. Each individual providing CHIS must complete a minimum of twelve (12) hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. The following criteria applies: (3-20-20)

a. Training must be relevant to the services being delivered. (3-20-20)

b. Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated as defined in the Medicaid Provider Handbook. (3-20-20)

c. Individuals who have not completed the required training during the previous calendar year, may not provide services in the current calendar year until the required number of training hours have been completed. (3-20-20)

d. Training hours may not be earned in the current calendar year to be applied to a future calendar year. (3-20-20)

e. Training topics can be repeated but the content of the continuing training must be different each calendar year; and (3-20-20)

576. CHIS: PROVIDER REIMBURSEMENT.

01. Reimbursement. The CHIS in Sections 570 through 577 of these rules are reimbursed as defined in IDAPA 16.03.10, Medicaid Enhanced Plan Benefits," Section 038. (3-20-20)

02. Claim Forms. Provider claims for payment must be submitted on claim forms provided or approved by the Department. General billing instructions will be provided by the Department. (3-20-20)

03. Rates. The reimbursement rates calculated for CHIS 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. (3-20-20)

577. CHIS: QUALITY ASSURANCE.

The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of the CHIS. Quality assurance activities will include the observation of service delivery with participants, face-to-face visits to review program protocol, and review of participant records maintained by the provider. All CHIS providers must grant the Department immediate access to all information requested to review compliance with these rules. (3-20-20)

01. Quality Assurance. Quality assurance consists of reviews to assure compliance with the Department's rules and regulations for CHIS. The Department will visit providers to monitor outcomes, assure

treatment fidelity, and assure health and safety. The Department will also gather information to assess family and participant satisfaction with services. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the participant. If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process will occur. (3-20-20)

02. Quality Improvement. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities may include any of the following: (3-20-20)

a. Consultation; (3-20-20)

b. Technical assistance and recommendations; or (3-20-20)

c. A Corrective Action. (3-20-20)

03. Corrective Action. Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practices identified during the review process as provided in Section 205.03 of these rules. Corrective action, as outlined in the Department's corrective action plan process, includes: (3-20-20)

a. Issuance of a corrective action plan; (3-20-20)

b. Referral to Medicaid Program Integrity Unit; or (3-20-20)

c. Action against a provider agreement. (3-20-20)

578. -- 579. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 580-649)

580. CHILD WELLNESS SERVICES: DEFINITIONS.

01. Interperiodic Medical Screens. Interperiodic medical screens are screens that are done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. (3-30-07)

02. Periodic Medical Screens. Interperiodic medical screens are screens done at intervals identified in the American Academy of Pediatrics periodicity schedule. (3-30-07)

581. CHILD WELLNESS SERVICES: PARTICIPANT ELIGIBILITY.
Child Wellness Services are available to all participants up to, and including, the month of their twenty-first (21st) birthday. (3-30-07)

582. CHILD WELLNESS SERVICES: COVERAGE AND LIMITATIONS.

01. Periodic Medical Screens. Periodic medical screens are to be completed according to the American Academy of Pediatrics periodicity schedule including blood lead tests at age twelve (12) months and twenty-four (24) months. The medical screen must include a blood lead test when the participant is age two (2) through age twenty-one (21) and has not been previously tested. (3-30-07)

02. Interperiodic Screens. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary (3-30-07)

03. Developmental Screens. Developmental screening is considered part of every routine initial and

periodic examination. If the screening identifies a developmental problem, then a developmental assessment will be ordered by the physician and be conducted by qualified professionals. (3-30-07)

583. (RESERVED)

584. CHILD WELLNESS SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Interperiodic Medical Screens. Interperiod medical screens must be performed by a physician, NP, or PA. (3-30-07)

02. Periodic Medical Screens. Periodic medical screens can be performed by a physician, NP, PA, or a Registered Nurse Screener. (3-30-07)

585. EARLY INTERVENTION SERVICES.
Early Intervention Services for infants and toddlers enrolled in Idaho Medicaid are provided by the Idaho Infant Toddler Program (ITP). Early Intervention Services must be provided in accordance with the Individuals with Disabilities Education Act (IDEA), Part C, and all Medicaid regulations. (7-1-18)

586. EARLY INTERVENTION SERVICES: PROGRAM REQUIREMENTS.
Idaho Medicaid and the ITP coordinate the delivery of Early Intervention Services through an intra-agency agreement published on the Department's website. Program requirements include: (7-1-18)

01. Physician Recommendation. The ITP can bill for health-related services provided to eligible children when the services are documented as medically necessary and provided under the recommendation of a physician. ITP may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated physician recommendation. The recommendation is valid for up to three hundred sixty-five (365) days. (7-1-18)

02. Individualized Family Service Plan (IFSP). The ITP may bill for Medicaid services covered by a current IFSP. The plan must be developed by a multi-disciplinary team and be based on the results of assessment(s). (7-1-18)

03. Qualified Staff. ITP staff qualifications must meet IDEA Part C requirements, and all Medicaid regulations as specified in the intra-agency agreement. (7-1-18)

587. EARLY INTERVENTION SERVICES: PROVIDER REIMBURSEMENT.
Medicaid will reimburse the Infant Toddler Program for covered medically necessary services. (7-1-18)

01. Fee Schedule. Reimbursement for Early Intervention Services will be based on the Idaho Medicaid Fee Schedule for Early Intervention. (7-1-18)

02. Payment Review. Reimbursement is subject to pre-payment and post-payment review in accordance with Section 56-209h(3), Idaho Code, and recoupment in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (7-1-18)

588. -- 589. (RESERVED)

590. ADULT PHYSICALS.
Adult preventive physical examinations are limited to one (1) per year. (3-30-07)

591. -- 601. (RESERVED)

602. SCREENING MAMMOGRAPHIES: COVERAGE AND LIMITATIONS.

01. Screening Mammographies. Screening mammographies are limited to one (1) per year for women who are forty (40) or more years of age. (3-30-07)

02. Diagnostic Mammographies. Diagnostic mammographies are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician orders the procedure for a participant of any age. (3-30-07)

603. (RESERVED)

604. SCREENING MAMMOGRAPHIES: PROVIDER QUALIFICATIONS AND DUTIES.
Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment and staff considered certifiable or certified by the Bureau of Laboratories. (3-30-07)

605. -- 609. (RESERVED)

610. CLINIC SERVICES: DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics that coordinate the treatment between physicians and other medical professionals for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (3-30-07)

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. (3-30-07)

02. Billings. No more than five (5) hours of medical social services per participant may be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of their participant. (3-30-07)

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. (3-30-07)

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. (3-30-07)

611. -- 617. (RESERVED)

618. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described in Section 620 of these rules. (3-30-07)

619. (RESERVED)

620. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.

01. Behavioral PHA. Benefits available to a participant specifically to support weight control. (3-20-14)

02. Benefit Year. A benefit year is twelve (12) continuous months. A participant's PHA benefit year begins the date their initial points are earned. (3-30-07)

03. PHA Benefit. A mechanism to reward healthy behaviors and good health choices of a participant eligible for preventive health assistance. (3-30-07)

04. Wellness PHA. Benefits available to a participant to support wellness. (3-20-14)

621. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have a Health Questionnaire on file with the Department. The Health Questionnaire is used to determine eligibility for a Behavioral PHA. The participant must indicate on the Health Questionnaire that they want to change a behavior related to weight management. The participant must meet one (1) of the following criteria: (3-20-14)

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (3-30-07)

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (3-30-07)

02. Wellness PHA. A participant who is required to pay premiums to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," is eligible for Wellness PHA. (3-30-07)

622. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. (3-29-10)

a. Maximum Benefit Points. (3-30-07)

i. The maximum number of points that can be earned for a Behavioral PHA is two hundred (200) points each benefit year. (3-30-07)

ii. The maximum number of points that can be earned for a Wellness PHA benefit is one hundred twenty (120) points each benefit year. (3-30-07)

b. Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year. (3-30-07)

c. Points earned for a specific participant's PHA benefit cannot be transferred to or combined with points in another participant's PHA benefit. (3-30-07)

02. Weight Management Program. Each program must provide weight management services and must include a curriculum that includes at least one (1) of the three (3) following areas: (3-30-07)

a. Physical fitness; (3-30-07)

b. Balanced diet; or (3-30-07)

c. Personal health education. (3-30-07)

03. Participant Request for Coverage. A participant can request that a previously unidentified service be covered. The Department will approve a request if the product or service meets the requirements described in this rule and the vendor meets the requirements in Section 624 of these rules. (3-20-14)

04. Premiums. (3-30-07)

a. Wellness PHA benefit points must be used to offset a participant's premiums. (3-29-10)

b. Only premiums that must be paid to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children" can be offset by PHA benefit points. (3-30-07)

05. Hearing Rights. A participant does not have hearing rights for issues arising between the participant and a chosen vendor. (3-30-07)

623. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. (3-30-07)

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Behavioral PHA. A participant must complete a PHA Benefit Agreement Form prior to earning any points. (3-30-07)

b. Each participant who chooses to enroll in weight management must participate in a physician approved or monitored weight management program. (3-20-14)

c. An initial one hundred (100) points are earned when the agreement form is received by the Department and the benefit is established. (3-30-07)

d. An additional one hundred (100) points can be earned by a participant who completes their program or reaches a chosen, defined goal. The vendor monitoring the participant's progress must verify that the program was completed or the goal was reached. (3-30-07)

02. Wellness PHA. (3-30-07)

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Wellness PHA. Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. (3-30-07)

b. Ten (10) points can be earned each month by a participant who receives all recommended wellness visits and immunizations for their age during the benefit year. (3-29-10)

624. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Agreement. A behavioral PHA vendor must have a fully-executed provider agreement on file with the Department prior to providing services or products. (3-29-10)

02. Prior Authorization. A behavioral PHA vendor must request prior authorization from the Department for each product or service provided as a PHA benefit. (3-29-10)

03. Medications and Pharmaceutical Supplies Vendor. Each vendor must be a licensed pharmacy and must meet the criteria in Section 664 of these rules for prescription drug provider qualifications and duties. (3-29-10)

04. Weight Management Program Vendor. Each vendor must: (3-20-20)

a. Be established as a business that serves the general public; (3-30-07)

b. Meet all state, county, and local business licensing requirements: and (3-30-07)

c. Be able to provide a weight management program as described in Section 622 of these rules. (3-30-07)

625. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.
With the prior agreement of the participant, the vendor may bill the participant for the difference between the Department's reimbursement and the vendor's usual and customary charge for Behavioral PHA products or services provided. (3-29-10)

626. PREVENTIVE HEALTH ASSISTANCE (PHA): QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of PHA. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. (3-30-07)

627. -- 629. (RESERVED)

630. NUTRITIONAL SERVICES: DEFINITIONS.
Nutritional services include intensive nutritional education, counseling, and monitoring. (3-30-07)

631. (RESERVED)

632. NUTRITIONAL SERVICES: COVERAGE AND LIMITATIONS.

01. Physician Referral. The need for nutritional services must be discovered by the screening services and ordered by the physician. (3-30-07)

02. Medically Necessary. The services must be medically necessary. (3-30-07)

633. (RESERVED)

634. NUTRITIONAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Nutritional services must be performed by a registered dietician or an individual who has a baccalaureate degree from a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. (3-30-07)

635. NUTRITIONAL SERVICES: PROVIDER REIMBURSEMENT.
Payment for nutritional services is made at a rate established in accordance with Section 230 of these rules. (3-30-07)

636. -- 639. (RESERVED)

640. DIABETES EDUCATION AND TRAINING SERVICES: DEFINITIONS.
For purposes of these rules, a Certified Diabetes Educator is a state-licensed health professional who is identified as a Certified Diabetes Educator according to the national standards of the National Certification Board for Diabetes Educators. (3-30-07)

641. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: (3-30-07)

01. Recent Diagnosis. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (3-30-07)

02. Uncontrolled Diabetes. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or (3-30-07)

03. Recent Manifestations. Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (3-30-07)

642. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only training and education services that are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. (3-30-07)

02. No Substitutions. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. (3-30-07)

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (3-30-07)

643. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order from the primary care provider who referred the participant to the program. (3-30-07)

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Outpatient diabetes education and training services will be covered under the following conditions: (3-30-07)

01. Meets Program Standards of the ADA. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association. (3-30-07)

02. Conducted by a Certified Diabetic Educator. The education and training services are provided by a Certified Diabetic Educator through a formal program. (3-13-20)T

645. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER REIMBURSEMENT.
Diabetes education and training services will be reimbursed according to the Department's established fee schedule in accordance with Section 230 of these rules. (3-30-07)

646. -- 649. (RESERVED)

SUB AREA: LABORATORY AND RADIOLOGY SERVICES
(Sections 650-659)

650. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.

01. Independent Laboratory. A laboratory that is not located in a physician's office, and receives specimens from a source other than another laboratory. A physician is not an independent laboratory. (7-1-19)

02. Laboratory or Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. (7-1-19)

03. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. (7-1-19)

04. Quality-Control. A day-to-day analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and includes an acceptable system to assure proper functioning of instruments, equipment and reagents. (7-1-19)

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. (7-1-19)

651. -- 652. (RESERVED)

653. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

01. Medical Necessity Criteria. Services must meet the definition of Medical Necessity in Section 011 of these rules as detailed in the Idaho Medicaid Provider Handbook. (7-1-19)

02. Prior Authorization of Services. The Department may require prior authorization of any laboratory or radiology service as detailed in the Idaho Medicaid Provider Handbook. (7-1-19)

654. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Laboratory and Radiology Requirements. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. (7-1-19)

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of Sections 650 through 659 of these rules are met by the reference laboratory. (7-1-19)

655. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Provider of Service. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of: (7-1-19)

a. An independent laboratory that can bill for a reference laboratory; (7-1-19)

b. A transplant facility that can bill for histocompatibility testing; and (7-1-19)

c. Healthcare professionals acting within the licensure and scope of their practice to comply with IDAPA 16.02.12, "Newborn Screening." (7-1-19)

02. Tests Performed by or Personally Supervised by a Physician. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (3-30-07)

03. Tests Performed by an Independent Laboratory. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-30-07)

04. Tests Performed by a Hospital Laboratory. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (3-30-07)

05. Specimen Collection Fee. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the physician or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection may be reimbursed even if prior authorization is not approved. (7-1-19)

656. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.
Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing consistent with federal requirements, as detailed in the Idaho Medicaid Provider Handbook. The laboratory must provide the results of proficiency testing to the Department or their Quality Improvement Organization vendor upon request. (7-1-19)

657. -- 659. (RESERVED)

SUB AREA: PRESCRIPTION DRUGS
(Sections 660-679)

660. (RESERVED)

661. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.

01. Obtaining a Prescription Drug. To obtain a prescription drug, a Medicaid participant or authorized agent must present the participant's Medicaid identification card to a participating pharmacy together with

a prescription from a licensed prescriber. (3-30-07)

02. Tamper-Resistant Prescription Requirements. Any written, non-electronic prescription for a Medicaid participant must be written on a tamper-resistant prescription form. The paper on which the prescription is written must have: (3-29-10)

a. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; (3-29-10)

b. One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; (3-29-10)

c. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. (3-29-10)

03. Tamper-Resistant Prescription Requirements Not Applicable. The tamper-resistant prescription requirements do not apply when the prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax, or when drugs are provided in an inpatient hospital or a nursing facility where the patient and family do not have direct access to the paper prescription. (3-29-10)

04. Drug Coverage for Dual Eligibles. For Medicaid participants who are also eligible for Medicare known as "dual eligibles", the Department will pay for Medicaid-covered drugs that are not covered by Medicare Part D. Dual eligibles will be subject to the same limits and processes used for any other Medicaid participants. (3-29-10)

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsections 662.06 and 662.07 of this rule that are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of prescription drugs or legend drugs, as defined under Section 54-1705, Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. (4-11-19)

02. Preferred Drug List (PDL). (4-11-19)

a. The PDL identifies the preferred drugs and non-preferred drugs within a therapeutic class designated by the Department and reviewed by the Idaho Medicaid Pharmacy and Therapeutics Committee. (4-11-19)

b. A brand name drug may be designated as a preferred drug by the Department if the net cost of the brand name drug after consideration of all rebates is less than the cost of the generic equivalent. (4-11-19)

c. The Director of the Department makes final decisions regarding the designated preferred or non-preferred status of drugs based on therapeutic recommendations from the Pharmacy and Therapeutics Committee and cost analysis from the Idaho Medicaid Pharmacy Program. (4-11-19)

d. Drugs in a drug class on the Medicaid PDL may require therapeutic prior authorization regardless of preferred or non-preferred designation. (4-11-19)

03. Covered Drug Products. Idaho Medicaid provides coverage to Medicaid participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: (4-11-19)

a. Agents, when used to promote smoking cessation. (4-11-19)

b. Prescription vitamins and mineral products. Covered agents include the following: (4-11-19)

i. Injectable vitamin B12 (cyanocobalamin and analogues); (4-11-19)

ii. Vitamin K and analogues; (4-11-19)

iii. Prescription vitamin D and analogues; (4-11-19)

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; (4-11-19)

v. Prenatal vitamins for pregnant or lactating individuals; and (4-11-19)

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. (4-11-19)

c. Certain prescribed non-prescription products, including the following: (4-11-19)

i. Permethrin; (4-11-19)

ii. Oral iron salts; (4-11-19)

iii. Disposable insulin syringes and needles; and (4-11-19)

iv. Insulin. (4-11-19)

d. Barbiturates. (4-11-19)

e. Benzodiazepines. (4-11-19)

04. Additional Criteria for Coverage. (4-11-19)

a. Medical necessity is the primary determinant of whether a therapeutic agent will be covered. The Department will cover generic drugs, and also brand drugs when medically necessary and when that necessity is adequately documented. If case-specific indications of medical necessity are present, the Department may also issue prior authorization for otherwise excluded drugs. (4-11-19)

b. The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, may determine that a non-prescription drug product is covered when the non-prescription product is found to be therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed by the Department to be a cost-effective alternative. Information regarding the Pharmacy and Therapeutics Committee and covered drug products is posted at http://medicaidpharmacy.idaho.gov. (4-11-19)

05. Excluded Drug Products. Idaho Medicaid excludes from coverage the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: (4-11-19)

a. Agents, when used to promote fertility. (4-11-19)

b. Agents, when used for cosmetic purposes or hair growth. (4-11-19)

c. Agents, when used for the symptomatic relief of cough and colds. (4-11-19)

d. Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. (4-11-19)

e. Agents, when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration. (4-11-19)

06. Additional Excluded Drugs. Drugs are also not covered when any of the following circumstances apply: (4-11-19)

a. The participant's practitioner has written an order for a prescription drug for which federal financial participation is not available. (4-11-19)

b. The participant's practitioner has written an order for a prescription drug that is deemed to be experimental or investigational, as defined in Subsection 390.03 of these rules. Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program. The Department may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. When approved for payment, reimbursement will be at actual acquisition cost, plus the assigned professional dispensing fee. (4-11-19)

07. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (3-30-07)

a. Maintenance Medications. Pharmacy providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two months or longer. The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov. (4-11-19)

b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (3-30-07)

663. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.
In accordance with Section 1927(d)(1)(A) of the Social Security Act, the Idaho Medicaid Pharmacy Program may subject any covered outpatient drug to prior authorization. (4-11-19)

01. Drugs Requiring Prior Authorization. No payment for drugs requiring prior authorization will be issued until the prior authorization request has been reviewed and approved by the Department. (4-11-19)

02. Prior Authorization Criteria. Criteria for prior authorization for individual drugs and drug classes will be determined by the Department, and will include: (4-11-19)

a. Food and Drug Administration (FDA) indications and labeling, including dosage guidelines. (4-11-19)

b. Compendia of drug information recognized by the Centers for Medicare and Medicaid Services (CMS), including: (4-11-19)

i. American Hospital Formulary Service-Drug Information; (4-11-19)

ii. United States Pharmacopeia-Drug Information, or its successor publications; and (4-11-19)

iii. The DrugDex Information System. (4-11-19)

c. Evidence-based, peer-reviewed, published medical literature, including: (4-11-19)

i. Systematic reviews; (4-11-19)

ii. Randomized controlled trials; and (4-11-19)

iii. Meta-analysis studies. (4-11-19)

d. Guidelines and case-controlled studies may be considered where systematic reviews, randomized controlled trials and meta-analysis studies do not exist. (4-11-19)

e. The requested drug's preferred drug status. (4-11-19)

03. Request for Prior Authorization. (4-11-19)

a. The prior authorization procedure is initiated by the prescriber who must submit the request to the Department in the format prescribed by the Department. (3-30-07)

b. Whenever possible, the Department will use automated authorization, in which claims are adjudicated at point of sale using submitted National Council for Prescription Drug Programs (NCPDP) data elements or claims history to verify that the Department's authorization requirements have been satisfied, without the need for the prescriber to submit additional clinical information. (4-11-19)

04. Notice of Decision. The Department will determine coverage based on this request, and will notify the participant of a denial. The participant has twenty-eight (28) days from the date the denial letter is mailed to appeal the decision. Hearings will be conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (4-11-19)

05. Emergency Situation. The Department will provide for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 U.S.C. 1396r-8(d)(5)(B). (3-30-07)

06. Response to Request. The Department will respond within twenty-four (24) hours to a request for prior authorization of a covered outpatient prescription drug as required in 42 U.S.C. 1396r-8(d)(5)(A). (3-30-07)

07. Prohibition Against Cash Payment for Controlled Substances. Pharmacy providers are prohibited from accepting cash as payment for controlled substances from persons known to be Medicaid participants. (4-11-19)

08. Supplemental Rebates. (3-30-07)

a. Purpose. The purpose of supplemental rebates is to enable the Department to purchase prescription drugs provided to Medicaid participants in a cost-effective manner. The supplemental rebate may be one (1) factor considered in determining a drug's preferred drug status, but it is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs. (4-11-19)

b. Rebate Amount. The Department may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. (3-30-07)

09. Comparative Costs to be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies. (3-30-07)

664. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Payment for Covered Drugs. Payment will be made, as provided in Section 665 of these rules, only to pharmacies registered with the Department as a provider for the specific location where the service was performed. An out of the state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy and be properly enrolled as a Medicaid provider. (3-30-07)

02. Dispensing Procedures. The following protocol must be followed for proper prescription filling. (3-30-07)

a. Prescription Drug Refills. Refills of prescription drugs must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription or logbook, or computer print-out, or on the participant's medication profile. (3-30-07)

b. Automatic Refills. (4-11-19)

i. Automatic refills are not allowed for Idaho Medicaid participants. A request specific to each medication is required. (4-11-19)

ii. All prescription refills must be initiated by a request from the participant, the prescriber, or another person, such as a family member, acting as an agent of the participant. (4-11-19)

iii. Authorization for each prescription refill must be received prior to the beginning of the filling process by the pharmacy. (4-11-19)

c. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: (3-30-07)

i. 21 CFR Section 1300, et seq.; (3-30-07)

ii. Title 54, Chapter 17, and Title 37, Chapters 1, 27, and 32, Idaho Code; (4-11-19)

iii. IDAPA 27.01.03, "Rules Governing Pharmacy Practice"; and (4-11-19)

iv. Sections 660 through 666 of these rules. (3-30-07)

d. Prescriptions on File. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request. (3-30-07)

03. Return of Unused Prescription Drugs. When prescription drugs were dispensed in unit dose packaging, as defined by IDAPA 27.01.03, "Rules Governing Pharmacy Practice," and the participant for whom the drugs were prescribed no longer uses them: (4-11-19)

a. A licensed skilled nursing care facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (3-30-07)

b. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (3-30-07)

04. Pharmacy Provider Receiving Unused Prescription Drugs. In order for a pharmacy provider to receive unused prescription drugs that it dispensed in unit dose packaging and that are being returned by a facility identified in Subsection 664.03 of this rule, the pharmacy provider: (3-30-07)

a. Must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice," regarding unit dose packaging; (4-11-19)

b. Must credit the Department the amount billed for the cost of the drug less the professional dispensing fee; and (4-11-19)

c. May receive a fee for acceptance of returned unused prescription drugs. The value of the unused prescription drug being returned must be such that return of the drug is cost-effective as determined by the Department. (3-30-07)

665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.

With specific exceptions as set forth in Subsections 665.01 through 665.04 of this rule, Idaho Medicaid pharmacy providers are reimbursed based on actual acquisition costs. Idaho Medicaid may require providers to supply documentation of their acquisition costs as described in the Medicaid Pharmacy Claims Submission Manual available at: https://idaho.fhsc.com/downloads/providers/IDRx_Pharmacy_Claims_Submission_Manual.pdf. Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program. (4-11-19)

01. Pharmacy Reimbursement. Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. The following protocol must be followed for proper reimbursement. (4-1-17)

a. Filing Claims. Pharmacies must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form must include information described in the pharmacy guidelines issued by the Department. (4-1-17)

b. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (3-30-07)

c. Reimbursement. Reimbursement to pharmacies is limited to the lowest of the following: (3-30-07)

i. Actual Acquisition Cost (AAC) based on results of the periodic state cost survey as defined in this rule, plus the assigned professional dispensing fee. In cases where no AAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC will mean the price, for a given calendar quarter, paid by a wholesaler for the drugs purchased from the wholesaler's supplier. The wholesaler's supplier is typically the manufacturer of the drug as published by a recognized compendium of drug pricing for the same calendar quarter; (4-11-19)

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned professional dispensing fee; (4-1-17)

iii. Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the professional dispensing fee assigned by the Department; or (4-11-19)

iv. The provider's usual and customary charge to the general public. (4-11-19)

d. Periodic State Cost Surveys. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Idaho Medicaid Pharmacy Program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. (4-11-19)

e. Physician Administered Drugs. (4-11-19)

i. Reimbursement to providers that are not 340B covered entities for medications administered to Medicaid participants by physicians or other qualified and licensed providers will be ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). If the ASP+6% rate is not available, payment will be at the Wholesale Acquisition Cost (WAC). (4-11-19)

ii. Reimbursement to 340B covered entities for medications administered to Medicaid participants by physicians or other qualified and licensed providers will be the actual 340B drug acquisition cost, not to exceed the 340B ceiling price. (4-11-19)

f. Clotting Factors. (4-11-19)

i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published

Medicare ASP+6% rate, plus the assigned professional dispensing fee. (4-11-19)

ii. Reimbursement to Hemophilia Treatment Centers will be the 340B actual acquisition cost, not to exceed the 340B ceiling price. (4-11-19)

g. Professional Dispensing Fee. Professional Dispensing Fee is defined as a tier-based amount paid on a pharmacy claim, over and above the ingredient cost, to compensate the provider for the pharmacist's professional services related to dispensing a prescription to a Medicaid participant, including: (4-11-19)

i. Looking up information about a participant's coverage on the computer; (4-11-19)

ii. Performing drug use reviews and preferred drug list review activities; (4-11-19)

iii. Measuring or mixing the covered outpatient drug; (4-11-19)

iv. Filling the container; (4-11-19)

v. Participant counseling; (4-11-19)

vi. Physically providing the completed prescription to the Medicaid participant; (4-11-19)

vii. Special packaging; and (4-11-19)

viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. (4-11-19)

h. Limitations on Payment of Professional Dispensing Fee. Only one (1) professional dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (4-11-19)

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (3-30-07)

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (3-30-07)

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (3-30-07)

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (3-30-07)

i. Tier-Based Professional Dispensing Fees. A professional dispensing fee for each pharmacy provider will be established in accordance with this rule. (4-11-19)

j. Claims Volume Survey for Tier-Based Professional Dispensing Fees. The Department will survey pharmacy providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department no later than May 31st each year. Pharmacy providers who do not complete the annual claims volume survey will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: http://healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/PharmacyReimbChangesFAQs.pdf. (4-1-17)

k. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic funds transfer. A remittance advice with detailed information of

each claim transaction will accompany each payment made by the Department. (4-1-17)

02. 340B Covered Entity Reimbursement. (4-1-17)

a. Participation as a 340B Covered Entity. Medicaid will reimburse 340B covered entities as defined in Section 340B of the Public Health Service Act, codified under 42 U.S.C. 256b(a)(4), when the provider meets the following requirements: (4-1-17)

i. A 340B covered entity may receive reimbursement for drugs provided to Idaho Medicaid participants through the 340B drug pricing program if the 340B covered entity submits its unique 340B identification number issued by the Health Resources and Services Administration (HRSA) and a copy of its completed HRSA 340B registration to Idaho Medicaid. (4-1-17)

ii. A 340B covered entity that elects to provide drugs to Idaho Medicaid participants through the 340B drug pricing program must use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic. A 340B covered entity must ensure that a contract pharmacy does not dispense drugs, or receive Medicaid reimbursement for drugs, acquired by the 340B covered entity through the 340B drug pricing program. An entity that does not use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic, will be deemed to be carved out of the 340B drug pricing program and will be reimbursed for brand name and generic drugs as provided in Subsection 665.01 of this rule. (4-11-19)

iii. A 340B covered entity must provide Idaho Medicaid with thirty (30) days advance written notice of its intent to discontinue the provision of drugs acquired through the 340B drug pricing program to Idaho Medicaid participants. (4-1-17)

b. Filing Claims. A 340B covered entity must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. The form must include information described in the pharmacy guidelines issued by the Department. (4-1-17)

c. Reimbursement Exclusions. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. (4-11-19)

d. Reimbursement. Reimbursement to 340B covered entities is limited to their actual 340B drug acquisition cost submitted, not to exceed the 340B ceiling price, plus the assigned professional dispensing fee. (4-11-19)

e. Professional Dispensing Fee. Only one (1) professional dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (4-1-17)

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (4-1-17)

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (4-1-17)

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (4-1-17)

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (4-1-17)

f. Tier-Based Professional Dispensing Fees. A professional dispensing fee for each 340B covered entity will be established in accordance with this rule. (4-1-17)

g. Remittance Advice. Claims are processed by computer, and payments are made directly to the 340B covered entity or its designated bank through electronic funds transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (4-1-17)

03. Reimbursement for Drugs Dispensed by Other Provider Types. (4-11-19)

a. Drugs acquired through non-340B Indian Health Service, Tribal, or Urban Indian pharmacies will be reimbursed at the actual acquisition cost to the entity, plus the assigned professional dispensing fee. (4-11-19)

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS actual acquisition cost, plus the assigned professional dispensing fee. (4-11-19)

c. Drugs acquired at nominal price, which is defined as pricing that is outside of 340B regulations or FSS, will be reimbursed at the actual acquisition cost, plus the assigned professional dispensing fee. (4-11-19)

d. Specialty drugs not dispensed by retail community pharmacies and dispensed primarily through the mail will be reimbursed at the Idaho actual acquisition cost, if such cost is available, plus the professional dispensing fee. If the actual acquisition cost is not available, drugs will be reimbursed at the lower of the Wholesale Acquisition Cost (WAC) or State Maximum Allowable Cost (SMAC) as established by the Department, plus the assigned professional dispensing fee. (4-11-19)

e. Drugs not distributed by a retail community pharmacy, such as drugs dispensed in a long-term care facility or dispensed to participants receiving swing-bed services, as described in Subsection 405.08 of these rules, will be reimbursed at the actual ingredient cost, plus the assigned professional dispensing fee. (4-11-19)

04. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: (4-11-19)

a. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (4-11-19)

b. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (4-11-19)

c. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (4-11-19)

05. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "General Provisions," must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: (4-11-19)

a. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice." (4-11-19)

b. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. (4-1-17)

c. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (3-30-07)

06. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online at: http://healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/PharmacyReimbChangesFAQs.pdf. (4-4-13)

666. PRESCRIPTION DRUGS: QUALITY ASSURANCE.

01. Pharmacy And Therapeutics Committee (P&T Committee). (3-30-07)

a. Membership. The P&T Committee is appointed by the Director and is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. (3-30-07)

b. Function. The P&T Committee has the following responsibilities for the prior authorization of drugs under Section 663 of these rules: (3-30-07)

i. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Pharmacy Program specific to the prior authorization of drugs. (4-11-19)

ii. To review evidence-based clinical and pharmacy economic data and recommend to the Department preferred and non-preferred drugs in classes designated for the Idaho Medicaid Preferred Drug List. (4-11-19)

iii. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation. (3-30-07)

iv. To review drug utilization outcome studies and intervention reports from the Drug Utilization Review Board as part of the process of reviewing and developing recommendations to the Department. (3-30-07)

c. Meetings. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. The P&T Committee may adjourn to executive session to consider the following: (3-30-07)

i. Relative cost information for prescription drugs that could be used by representatives of pharmaceutical manufacturers or other people to derive the proprietary information of other pharmaceutical manufacturers; or (3-30-07)

ii. Participant-specific or provider-specific information. (3-30-07)

667. -- 679. (RESERVED)

SUB AREA: FAMILY PLANNING
(Sections 680-699)

680. (RESERVED)

681. FAMILY PLANNING SERVICES: PARTICIPANT ELIGIBILITY.

01. Sterilization Procedures -- General Restrictions. The following restrictions govern payment for sterilization procedures for eligible persons. (3-30-07)

a. No sterilization procedures will be paid on behalf of a participant who is not at least twenty-one (21) years of age at the time they sign the informed consent. (3-30-07)

b. No sterilization procedures will be paid on behalf of any participant who is twenty-one (21) years of age or over and who is incapable of giving informed consent. (3-30-07)

c. Each participant must voluntarily sign the properly completed “Consent Form” HW 0034, or its equivalent, in the presence of the person obtaining consent in accordance with Section 683 of these rules. (3-30-07)

d. Each participant must sign the “Consent Form” at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures. Exceptions to these time requirements are described under Subsection 682.03 of these rules. (3-30-07)

02. Circumstances Under Which Payment Can be Made for a Hysterectomy. Payment can be made for a hysterectomy only if: (3-30-07)

a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and (3-30-07)

b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and (3-30-07)

c. The participant was advised orally and in writing that sterility would result and that she would no longer be able to bear children; and (3-30-07)

d. The participant signs and dates an "Authorization for Hysterectomy" form. The form must state "I have been informed orally and in writing that a hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed." (3-30-07)

682. FAMILY PLANNING SERVICES: COVERAGE AND LIMITATIONS.
Family planning includes counseling and medical services prescribed or performed by an independent licensed physician, or a qualified certified nurse practitioner or physician's assistant. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. (3-30-07)

01. Contraceptive Supplies. (3-30-07)

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (3-30-07)

b. Contraceptives requiring a prescription are payable subject to Section 662 of these rules. (3-30-07)

c. Payment for oral contraceptives is limited to purchase of a three (3) month supply. (3-30-07)

02. Sterilization. (3-30-07)

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are eligible for payment unless such sterilizations are ordered by a court of law. (3-30-07)

b. Hysterectomies performed solely for sterilization purposes are not eligible for payment (see Subsection 681.02 of these rules for those conditions under which a hysterectomy can be eligible for payment). (3-30-07)

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (3-30-07)

d. Suitable arrangements must be made to insure that information as specified in Subsection 681.01 of these rules is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise disabled. (3-30-07)

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and (3-30-07)

a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and (3-30-07)

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (3-30-07)

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (3-30-07)

04. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization. In addition they must: (3-30-07)

a. Certify, by signing a properly completed "Consent Form" HW 0034, or its equivalent, and submitting the consent form with their claim, that all requirements have been met concerning sterilizations; and (3-30-07)

b. Submit to the Department a copy of the court order together with the "Consent Form" and claim. (3-30-07)

683. FAMILY PLANNING SERVICES: PROCEDURAL REQUIREMENTS.

01. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form" HW 0034, or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. (3-30-07)

a. The consent form must be signed and dated by: (3-30-07)

i. The participant to be sterilized; and (3-30-07)

ii. The interpreter, if one (1) is provided; and (3-30-07)

iii. The individual who obtains the consent; and (3-30-07)

iv. The physician who will perform the sterilization procedure. (3-30-07)

v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (3-30-07)

b. Informed consent must not be obtained while the participant in question is: (3-30-07)

i. In labor or childbirth; or (3-30-07)

ii. Seeking to obtain or obtaining an abortion; or (3-30-07)

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. (3-30-07)

c. An interpreter must be provided if the participant does not understand the language used on the consent form or the language used by the person obtaining the consent. (3-30-07)

d. The person obtaining consent must: (3-30-07)

i. Offer to answer any questions the participant may have concerning the procedure; and (3-30-07)

ii. Orally advise the participant that they are free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting their right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and (3-30-07)

iii. Provide a description of available alternative methods of family planning and birth control; and (3-30-07)

iv. Orally advise the participant that the sterilization procedure is considered to be irreversible; and (3-30-07)

v. Provide a thorough explanation of the specific sterilization procedure to be performed; and (3-30-07)

vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and (3-30-07)

vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and (3-30-07)

viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 682.03 of these rules. (3-30-07)

e. The person securing the consent from the participant must certify by signing the "Consent Form" that: (3-30-07)

i. Before the participant signed the consent form, they were advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and (3-30-07)

ii. The requirements for informed consent as set forth on the consent form were orally explained; and (3-30-07)

iii. To the best of their knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization. (3-30-07)

f. The physician performing the sterilization must certify by signing the "Consent Form" that: (3-30-07)

i. At least thirty (30) days have passed between the participant's signature on that form and the date the sterilization was performed; and (3-30-07)

ii. To the best of the physician's knowledge the participant is at least twenty-one (21) years of age; and (3-30-07)

iii. Before the performance of the sterilization the physician advised the participant that no federal benefits will be withdrawn because of the decision to be or not to be sterilized; and (3-30-07)

iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form"; and (3-30-07)

v. To the best of their knowledge and belief the participant to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization. (3-30-07)

g. If an interpreter is provided, they must certify by signing the "Consent Form" that: (3-30-07)

i. They accurately translated the information and advice presented orally to the participant; and (3-30-07)

ii. They read the "Consent Form" and accurately explained its contents; and (3-30-07)

iii. To the best of their knowledge and belief, the participant understood the interpreter. (3-30-07)

h. The person obtaining consent must sign the "Consent Form" and certify that they have fulfilled

specific requirements in obtaining the participant's consent. (3-30-07)

i. The physician who performs the sterilization must sign the "Consent Form" HW 0034, certifying that the requirements of this rule have been fulfilled. (3-30-07)

684. (RESERVED)

685. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (3-30-07)

686. -- 699. (RESERVED)

SUB AREA: BEHAVIORAL HEALTH SERVICES
(Sections 700-719)

700. INPATIENT BEHAVIORAL HEALTH SERVICES: DEFINITIONS.

01. Freestanding Psychiatric Hospital. A hospital, nursing facility, or other institution of sixteen (16) beds or less that is primarily engaged in the diagnosis and treatment of mental diseases. The hospital is not considered freestanding if it shares a building or campus with another hospital, or is owned by another hospital. (7-1-18)

02. Hospital Psychiatric Unit. The psychiatric unit of a general hospital that furnishes inpatient care and treatment services for mental illness under a psychiatrist or other physician qualified to treat mental diseases. (7-1-18)

03. Institutions for Mental Disease (IMD). A hospital, nursing facility or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. A specific licensure is not necessary to meet this definition. This definition does not apply to ICF/IDs. (7-1-18)

04. Substance Use Disorder. A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance and the current DSM. (7-1-18)

701. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants are eligible who have a diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: (7-1-18)

a. A freestanding psychiatric hospital; (7-1-18)

b. A hospital psychiatric unit; and (3-20-20)T

c. Subject to federal approval, an institution for mental diseases. (3-20-20)T

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. (3-20-20)T

03. Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. (7-1-18)

a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of their psychiatric illness: (3-20-20)T

i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-30-07)

(1) Has actually made an attempt to take their own life in the last seventy-two (72) hours (details of the attempt must be documented); or (3-20-20)T

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-30-07)

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the participant or a reliable source and details of the participant's plan must be documented); or (7-1-18)

(4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or (7-1-18)

ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms that indicate they are a probable danger to others as indicated by one (1) of the following: (3-20-20)T

(1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property that would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (3-20-20)T

(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property that would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (3-20-20)T

(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-18)

iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-18)

(1) The participant has such limited functioning that their physical safety and well being are in jeopardy due to their inability for basic self-care, judgment, and decision making (details of the functional limitations must be documented); or (3-20-20)T

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or (7-1-18)

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. (3-20-20)T

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. (7-1-18)

04. Intensity of Service Criteria. The participant must meet all of the following criteria related to the intensity of services needed for treatment. (7-1-18)

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and (7-1-18)

b. The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-18)

c. Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. (7-1-18)

d. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in their current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (3-20-20)T

05. Exclusions. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (7-1-18)

a. The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-18)

b. The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. (7-1-18)

702. INPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Initial Length of Stay. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. (7-1-18)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. (7-1-18)

703. INPATIENT BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department, or its designee. The Department will set documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. Requests for prior authorization must include: (7-1-18)

a. Diagnosis; and (3-30-07)

b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (3-30-07)

c. Medical history; and (3-30-07)

d. Mental and physical functional capacity; and (3-30-07)

e. Prognosis. (7-1-18)

02. Individual Plan of Care – Content. The individual plan of care is a written plan developed for the participant upon admission. The objective of the plan is to improve their condition to the extent that acute psychiatric care is no longer necessary. It must be developed by an interdisciplinary team as defined in Subsection 703.03 of this rule. The plan of care must be implemented within seventy-two (72) hours of admission, and reviewed at least every three (3) days. The individual plan of care must contain: (7-1-18)

a. A diagnostic evaluation that includes examination of the medical, behavioral, and developmental

aspects of the participant's situation and reflects the medical necessity for in-patient care; and (7-1-18)

b. Treatment objectives related to conditions that necessitated the admission; and (7-1-18)

c. An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives; and (7-1-18)

d. A discharge plan designed to achieve the participant's discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant's family, school, and community upon discharge. (7-1-18)

03. Individual Plan of Care – Interdisciplinary Team. The individual plan of care must be developed by an interdisciplinary team capable of assessing the participant's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the participant's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: (7-1-18)

a. One (1) of the following: (7-1-18)

i. A board-certified psychiatrist; or (7-1-18)

ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (3-30-07)

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and (3-30-07)

b. One (1) of the following: (7-1-18)

i. A licensed, clinical or master's social worker; or (7-1-18)

ii. A registered nurse with specialized training or one (1) year's experience in treating individuals with behavioral health needs; or (7-1-18)

iii. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating individuals with behavioral health needs, (7-1-18)

c. The participant and their parents, legal guardians, or others into whose care they will be released after discharge. (3-30-07)

704. INPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Qualifications. Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. (7-1-18)

02. Record Keeping. A written report of each evaluation and the plan of care must be entered into the participant's record at the time of admission or if the participant is already in the facility, immediately upon completion of the evaluation or plan. (7-1-18)

03. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each participant's need for the services that the hospital furnishes them. The UR plan must

meet the requirements under 42 CFR 456.201 through 456.245. (7-1-18)

705. INPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.
Failure to request a prior authorization, concurrent review, or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the stay is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The admitting physician will be assessed a penalty for failure to request a prior authorization, concurrent review, or continued stay review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. (7-1-18)

01. Payment. Reimbursement for the participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. (7-1-18)

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (3-30-07)

02. Hospital Penalty Schedule. Failure to request a prior authorization, concurrent review, or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission. (7-1-18)

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars ($260). (3-30-07)

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars ($520). (3-30-07)

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars ($780). (3-30-07)

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars ($1,040). (3-30-07)

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars ($1,300). (3-30-07)

03. Physician Penalty Schedule. Failure to request a preadmission review from the Department in a timely manner will result in the admitting physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: (7-1-18)

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars ($50). (3-30-07)

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars ($100). (3-30-07)

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars ($150). (3-30-07)

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars ($200). (3-30-07)

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars ($250). (3-30-07)

706. INPATIENT BEHAVIORAL HEALTH SERVICES: QUALITY ASSURANCE.
The policy, rules, and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482. (7-1-18)

707. OUTPATIENT BEHAVIORAL HEALTH SERVICES.
Outpatient behavioral health services are contained in the "Idaho Behavioral Health Plan" (IBHP) that is authorized by a 1915(b) waiver authority and delivered under a PAHP contract. The IBHP allows for the contractor to provide the administration of community-based outpatient behavioral health services for individuals, based on medical necessity, that include therapeutic and rehabilitative treatment intended to minimize symptoms of mental illness, emotional disturbance, and substance use disorders. These services also help restore independent functioning to the greatest extent possible. For more information, please visit the IBHP website at: http://www.optumidaho.com/. (3-20-14)

708. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare-Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary. (3-20-14)

709. OUTPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Community-Based Outpatient Behavioral Health Services. The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include: (3-20-14)

a. Assessments and Planning; (3-20-14)

b. Psychological and Neurological Testing; (3-20-14)

c. Psychotherapy (Individual, Group, and Family); (3-20-14)

d. Pharmacologic Management; (3-20-14)

e. Partial Care Treatment; (3-20-14)

f. Behavioral Health Nursing; (3-20-14)

g. Drug Screening; (3-20-14)

h. Community-Based Rehabilitation; (3-20-14)

i. Substance Use Disorder Treatment Services; and (3-20-14)

j. Case Management. (3-20-14)

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. (3-20-14)

710. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS.
The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department. (3-20-14)

711. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the IBHP with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. (3-20-14)

01. Administer IBHP. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service. (3-20-14)

02. Authorization. The contractor is responsible for authorization of covered behavioral health services that require authorization prior to claim payment. (3-20-14)

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled through a process between the contractor and Department that is in compliance with state and federal requirements. Participants must utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. (3-20-14)

712 -- 719. (RESERVED)

SUB AREA: HOME HEALTH SERVICES
(Sections 720-729)

720. HOME HEALTH SERVICES: DEFINITIONS.

01. Home Health Plan of Care. A written description of home health services to be provided to a participant. (7-1-17)

02. Home Health Services. Home health services are services and items, including nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances that are: (7-1-17)

a. Ordered by a physician as part of a home health plan of care; (7-1-17)

b. Performed by a licensed, qualified professional acting within their authorized scope of practice; (7-1-17)

c. Typically received by a participant at the participant's place of residence, but may be received in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/ID (unless such services are not otherwise required to be provided by the ICF/ID), or any other setting in which payment is made, or could be made, under Medicaid for inpatient services that include room and board; and (7-1-17)

d. Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)

03. Place of Residence. For the purposes of home health services, generally any setting in which a participant makes their home, other than a hospital, nursing facility, or ICF/ID. (7-1-17)

721. (RESERVED)

722. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

Home health visits are limited to one hundred (100) visits per calendar year per person. (3-30-07)

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Physician Orders. (7-1-17)

a. Home health services must be ordered by a physician. Such orders must include at a minimum, the physician's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. (7-1-17)

b. In the event that home health services are required for extended periods, these services must be reordered as necessary, but at least every sixty (60) days for services and at least annually for medical supplies, equipment, and appliances. (7-1-17)

02. Face-to-Face Encounter for Home Health Services -- Excluding Medical Supplies, Equipment, and Appliances. (7-1-17)

a. For the initiation of home health services, excluding medical supplies, equipment, and appliances, the participant's physician must document that a face-to-face encounter that is related to the primary reason the patient requires home health services occurred with the participant no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. Appropriate documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. (7-1-17)

b. The face-to-face encounter may occur via telehealth, as defined in Title 54, Chapter 57, Idaho Code. (7-1-17)

c. The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP): (7-1-17)

i. A nurse practitioner or clinical nurse specialist working in collaboration with the ordering physician; (7-1-17)

ii. A nurse midwife; or (7-1-17)

iii. A physician assistant under the supervision of the ordering physician. (7-1-17)

d. If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face-to-face encounter to the ordering physician. (7-1-17)

03. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances. (7-1-17)

a. For the initiation of home health medical supplies, equipment, and appliances, the participant's physician, or a non-physician practitioner as authorized in Subsection 723.03 of this rule, must document that a face-to-face encounter that is related to the primary reason the patient requires medical supplies, equipment, and appliances, occurred with the participant no more than six (6) months before the start of services. Appropriate documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. (7-1-17)

b. The face-to-face encounter may occur via telehealth, as defined in Title 54, Chapter 57, Idaho Code. (7-1-17)

c. The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP): (7-1-17)

i. A nurse practitioner or clinical nurse specialist working in collaboration with the ordering

physician; or (7-1-17)

ii. A physician assistant under the supervision of the ordering physician. (7-1-17)

d. If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face-to-face encounter to the ordering physician. (7-1-17)

04. Home Health Plan of Care. (7-1-17)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment. The home health plan of care must be signed by the licensed, qualified professional who established the plan and must contain the information required under IDAPA 16.03.07, "Home Health Agencies." (7-1-17)

b. All home health plans of care must be reviewed by the participant's physician as necessary, but at least every sixty (60) days for services, and at least annually for medical supplies, equipment, and appliances. (7-1-17)

724. HOME HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In order to participate as a Home Health Agency (HHA) provider for Medicaid-eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status. (3-30-07)

725. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Mileage Included in Cost. Payment by the Department for home health services will include mileage as part of the cost of the visit. (3-30-07)

02. Payment Procedures. Payment for home health services will be limited to the services authorized in Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by Medicare or the Medicaid percentile cap. (3-30-07)

a. For visits performed in the first state fiscal year for which this Subsection is in effect, the Medicaid percentile cap will be established at the seventy fifth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Department on June 1, 1987. Thereafter, the percentile cap will be revised annually, effective at the beginning of each state fiscal year. Revisions will be made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. (3-30-07)

b. When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the participant, the total rental cost of a Durable Medical Equipment (DME) item must not exceed one-tenth (1/10) of the total purchase price of the item. A minimum rental rate of fifteen dollars ($15) per month is allowed on all DME items. (7-1-17)

c. The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment. (3-30-07)

d. The Department will not pay for services at a cost in excess of prevailing Medicare rates. (3-30-07)

e. If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and co-insurance amounts that the Department will pay. (3-30-07)

726. -- 729. (RESERVED)

SUB AREA: THERAPY SERVICES
(Sections 730-739)

730. THERAPY SERVICES: DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: (4-2-08)

01. Duplicate Services. Services are considered duplicate: (4-2-08)

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or (4-2-08)

b. When more than one (1) type of therapy is provided at the same time. (4-2-08)

02. Feeding Therapy. Feeding Therapy means those therapy services necessary for the treatment of feeding disorders. Feeding disorders include problems gathering food and getting ready to suck, chew, or swallow it. (7-1-16)

03. Maintenance Program. A program established by a therapist that requires the skills of a therapist or therapy professional and consists of activities and mechanisms to assist a participant in maximizing or maintaining the progress they have made during therapy or to prevent or slow further deterioration due to a disease or illness. (7-1-16)

04. Occupational Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed occupational therapy professionals; (7-1-16)

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (4-2-08)

c. Improve the individual's ability to perform those tasks required for independent functioning. (4-2-08)

05. Physical Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed physical therapy professionals; (7-1-16)

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and (4-2-08)

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (4-2-08)

06. Speech-Language Pathology Services. Therapy services that are: (4-2-08)

a. Provided within the scope of practice of licensed speech-language pathologists; and (4-2-08)

b. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or (4-2-08)

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (4-2-08)

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (4-2-08)

08. Therapist. An individual licensed by the appropriate Idaho state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. (7-1-16)

09. Therapy Professional. An individual licensed by the appropriate Idaho state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist. (7-1-16)

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's attending physician, nurse practitioner, or physician assistant as part of a plan of care. (4-2-08)

11. Treatment Modalities. A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. (4-2-08)

731. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.
To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: (4-2-08)

01. Physician Order. A physician order for therapy services; and (7-1-16)

02. A Therapy Evaluation Showing Need. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and (4-2-08)

03. A Therapy Evaluation Establishing Participant Benefit. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. (4-2-08)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, independent practitioners, and home health agencies. Therapy services provided by a home health agency under a home health plan of care must meet the requirements found in Sections 730 through 739 of these rules, and the requirements found in Sections 720 through 729 of these rules. (7-1-18)

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT Manual) are covered with the following limitations: (4-2-08)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (4-2-08)

b. Any CPT procedure code that falls under the heading of either, “Active Wound Care Management,” or “Tests and Measurements,” requires the therapist to have direct, one-to-one (1:1) patient contact. (4-2-08)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. (4-2-08)

d. Any assessment provided under the heading “Orthotic Management and Prosthetic Management” must be completed by the therapist. (4-2-08)

e. Any modality that is defined as “unlisted” in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. (4-2-08)

f. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the

service. The therapist has full responsibility for the service provided. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. (7-1-16)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (7-1-16)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (4-2-08)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. (7-1-16)

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a therapy professional. (7-1-16)

d. Massage, work hardening, and conditioning. (4-2-08)

e. Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

f. Duplicate services, as defined under Section 730 of these rules. (4-2-08)

g. Acupuncture (with or without electrical stimulation). (7-1-16)

h. Biofeedback, unless provided to treat urinary incontinence. (7-1-16)

i. Duplicate Services. (7-1-16)

j. Services that are considered to be experimental or investigational. (7-1-16)

k. Vocational Program. (7-1-16)

l. Vision Therapy. (7-1-16)

04. Service Limitations. (4-2-08)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (7-1-17)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (7-1-17)

c. Exceptions to service limitations. (3-29-12)

i. Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. (3-29-12)

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (7-1-13)

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the

EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. (3-29-12)

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. (7-1-16)

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. (7-1-16)

f. Telehealth modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on telehealth in the provider handbook to promote quality services and program integrity. (7-1-16)

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a physician, nurse practitioner, or physician assistant as part of a plan of care. (7-1-16)

01. Physician Orders. (4-2-08)

a. All therapy must be ordered by a physician, nurse practitioner, or physician assistant. Such orders must include at a minimum, the service to be provided, the frequency, and, where applicable, the expected duration of time for which the therapy will be needed. If the initial order is to evaluate and treat, but does not specify at least the type of service ordered and the frequency, then: (7-1-16)

i. The therapist may perform a therapy evaluation based on the initial physician order for the evaluation; and (7-1-16)

ii. The therapist must then develop a therapy plan of care based on that evaluation and send the plan to the ordering physician, nurse practitioner, or physician assistant and begin care; and (7-1-16)

iii. The physician, nurse practitioner, or physician assistant must either sign an order specifying the service to be provided, the frequency and the duration, or they must sign the therapy plan of care that includes that information within thirty (30) days for therapy to continue. No claims may be billed until the complete order or the plan of care is signed by the physician, nurse practitioner, or physician assistant. (7-1-16)

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: (5-8-09)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (4-2-08)

ii. Therapy for individuals with long-term medical conditions, as documented by physician, nurse practitioner, or physician assistant, must be reordered at least every three hundred sixty-five (365) days. (7-1-16)

c. Therapy services provided under a home health plan of care must comply with the physician order requirements in Section 723 of these rules. (7-1-17)

02. Level of Supervision. Supervision of physical therapist assistants and occupational therapist assistants by the physical therapist or occupational therapist must be done according to the rules of the applicable licensure board. (7-1-16)

03. Face-to-Face Encounter for Home Health Therapy Services. Therapy services provided under a home health plan of care must comply with the face-to-face encounter requirements in Section 723 of these rules. (7-1-17)

04. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is established prior to beginning treatment. (7-1-17)

a. The plan of care must be signed by the person who established the plan. (7-1-17)

b. The plan of care must be consistent with the therapy evaluation and must contain, at a minimum: (7-1-17)

i. Diagnoses; (7-1-16)

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (7-1-16)

iii. Type, frequency, and duration of therapy services. (7-1-16)

c. Therapy services provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (7-1-17)

734. THERAPY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The following providers are qualified to provide therapy services as Medicaid providers. (4-2-08)

01. Occupational Therapist, Licensed. A person licensed by the State Board of Medicine to conduct occupational therapy assessment and therapy in accordance with the Occupational Therapy Practice Act, Title 54, Chapter 37, Idaho Code, and IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (7-1-16)

02. Physical Therapist, Licensed. A person licensed by the Physical Therapy Licensure Board to conduct physical therapy assessments and therapy in accordance with the Physical Therapy Practice Act, Title 54, Chapter 22, Idaho Code, and IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board." (4-2-08)

03. Speech-Language Pathologist, Licensed. A person licensed by the Speech and Hearing Services Licensure Board to conduct speech-language assessments and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, and IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language, and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. (4-2-08)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (4-2-08)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Home Health Agencies." (4-2-08)

b. Therapists enrolled with Medicaid as independent practitioners and licensed by the appropriate state licensing board will be reimbursed on a fee-for-service basis. Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid. (3-20-14)

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (4-2-08)

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (4-2-08)

736. THERAPY SERVICES: QUALITY ASSURANCE ACTIVITIES.

01. Unreimbursable Services and Penalties. Therapy services that are not medically necessary or that are not specifically covered by these rules are not reimbursable, and if paid are subject to recoupment and penalties under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (4-2-08)

02. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules in IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," or IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," or IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," as well as the applicable association's professional Code of Ethics and Standards supporting best practice. (4-2-08)

03. Documentation. (4-2-08)

a. The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Section 305 of these rules. (4-2-08)

b. The following documentation must be maintained in the files of the provider: (4-2-08)

i. Physician, nurse practitioner, or physician assistant orders for therapy services; (4-2-08)

ii. Therapy plans of care; and (4-2-08)

iii. Progress or other notes documenting each assessment, each therapy session, and results of tests and measurements related to therapy services. (4-2-08)

c. The provider must grant the Department immediate access to all information required to review compliance with these rules, as required in Section 330 of these rules. The absence of such documentation is cause for recoupment of Medicaid payment. (4-2-08)

737. -- 739. (RESERVED)

SUB AREA: AUDIOLOGY SERVICES
(Sections 740-749)

740. AUDIOLOGY SERVICES.
Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist. These services must be provided in accordance with Title 54, Chapter 29, Idaho Code, and require the order of a physician, nurse practitioner, or physician assistant. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. (4-2-08)

741. AUDIOLOGY SERVICES: PARTICIPANT ELIGIBILITY.

01. All Participants. All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. (3-29-12)

02. Participants Under the Age of 21. Participants under the age of twenty-one (21) are eligible for all services listed in Section 742 of these rules. (3-29-12)

742. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
All audiology services must be ordered by a physician or non-physician practitioner. The Department will pay for

routine audiometric examination and testing once in each calendar year, and audiometric services and supplies in accordance with the following guidelines and limitations: (7-1-17)

01. Non-Implantable Hearing Aids. When there is a documented hearing loss of at least thirty (30) decibels based on the standard Pure Tone Average (500, 1000, 2000 hertz), the Department will cover the purchase of non-implantable hearing aids for participants under the age of twenty-one (21) with the following requirements and limitations: (3-29-12)

a. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (3-30-07)

b. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21): batteries purchased on a monthly basis, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting. (3-29-12)

c. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended. (3-30-07)

02. Implantable Hearing Aids. The Department may cover a surgically implantable hearing aid for participants under the age of twenty-one (21) when: (3-29-12)

a. There is a documented hearing loss as described in Subsection 742.01 of this rule; (4-2-08)

b. Non-implantable options have been tried, but have not been successful; and (4-2-08)

c. The Department has determined that a surgically implanted hearing aid is medically necessary through the prior authorization process. The Department will consider the guidelines of private and public payers, evidence-based national standards or medical practice, and the medical necessity of each participant's case. (3-29-12)

03. Provider Documentation Requirements. The following information must be documented and kept on file by the provider: (4-2-08)

a. The participant's diagnosis; (4-2-08)

b. The results of the basic comprehensive audiometric exam that include pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and (4-2-08)

c. The brand name and model type of the hearing aid needed. (4-2-08)

04. Allowance to Waive Impedance Test. The Department will allow a medical doctor to waive the impedance test based on their documented judgment. (4-2-08)

743. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Audiology Examinations. Basic audiometric testing by licensed audiologists or licensed physicians will be covered without prior approval. (3-30-07)

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done and kept on file by the provider. (3-30-07)

744. AUDIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The following are qualified to provide audiology services as Medicaid providers: (3-30-07)

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. (3-30-07)

02. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. (3-30-07)

745. AUDIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedures. The following procedures must be followed when billing the Department: (3-30-07)

a. The Department will only pay the hearing aid provider for an eligible Medicaid participant if a properly completed claim is submitted to the Department within the one (1) year billing limitation. (3-30-07)

b. Payment will be based upon the Department's fee schedule in accordance with Section 230 of these rules). (3-30-07)

02. Limitations. The following limitations apply to audiometric services and supplies: (3-30-07)

a. Hearing aid selection is restricted to the most cost-effective type and model that meets the participant's medical needs. (3-30-07)

b. Follow-up services are included in the purchase of the hearing aid for the first two (2) years including repair, servicing and refitting of ear molds. (3-20-20)

c. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased from them by the Department and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid. (3-30-07)

d. Providers must not bill participants for charges in excess of the fees allowed by the Department for materials and services. (3-30-07)

746. -- 749. (RESERVED)

SUB AREA: DURABLE MEDICAL EQUIPMENT AND SUPPLIES
(Sections 750-779)

750. (RESERVED)

751. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PARTICIPANT RESPONSIBILITY.
The participant has a responsibility to reasonably protect and preserve equipment issued to them. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse or abuse are the responsibility of the participant. (7-1-17)

752. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: COVERAGE AND LIMITATIONS.
The Department will purchase or rent, when medically necessary, reasonable and cost-effective, durable medical equipment (DME) and medical supplies that are suitable for use in any setting in which normal life activities take place. Medical supplies, equipment, and appliances provided by a home health agency under a home health plan of care must meet the requirements found in Sections 750 through 779 of these rules and the requirements found in Sections 720 through 729 of these rules. (7-1-17)

01. Medical Necessity Criteria -- Equipment and Supplies. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the CMS/ Medicare DME coverage manual. Exceptions to Medicare coverage are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Items for convenience, comfort, or cosmetic reasons are not covered. (7-1-17)

02. Prior Authorization -- Equipment and Supplies. (7-1-17)

a. Unless otherwise specified by the Department in the provider handbook, durable medical equipment and medical supplies require prior authorization by the Department. (7-1-17)

b. Each request for prior authorization must include all medical necessity documentation required under Section 753 of these rules. (7-1-17)

c. The Medicaid fee schedule that identifies medical supplies, equipment, and appliances commonly ordered for Medicaid participants, is not a comprehensive list of all medical supplies, equipment, and appliances available to Medicaid participants. If a participant requires an item that is not listed on the fee schedule, a request may be submitted to the Department to assess items for coverage. This request must include justification of the medical necessity, amount of, and duration for the item or service. (7-1-17)

03. Coverage Conditions -- Equipment. Medical equipment is subject to coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary equipment not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. (7-1-17)

04. Coverage Conditions -- Supplies. (7-1-17)

a. The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period for the treatment or amelioration of a medical condition identified by the attending physician. Supplies in excess of the limitations in the CMS/Medicare DME coverage manual must be prior authorized by the Department. (3-13-20)T

b. Medical supplies are subject to the coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary supplies not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. (7-1-17)

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Physician Orders. (7-1-17)

a. All medical supplies, equipment, and appliances must be ordered by a physician or non-physician practitioner acting within the scope of their licensure. Such orders must meet the requirements described in the CMS/ Medicare DME coverage manual. (3-13-20)T

b. Date of delivery is considered the date of service. (7-1-17)

c. In the event that medical equipment and supplies are required for extended periods, these must be reordered as necessary, but at least annually, for all participants. (7-1-17)

d. The following information to support the medical necessity of the item(s) must be included in the physician's order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: (7-1-17)

i. The participant's medical diagnosis, including current information on the medical condition that

requires the use of the supplies or medical equipment, or both; (7-1-17)

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; (7-1-17)

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; (7-1-17)

iv. For medical supplies, the type and quantity of supplies necessary must be identified; and (7-1-17)

v. Documentation of the participant's medical necessity for the item, that meets coverage criteria in the CMS/Medicare DME coverage manual. (7-1-17)

vi. Additional information may be requested by the Department for specific equipment or supplies, or both, including equipment for which CMS/Medicare has established no coverage criteria. (7-1-17)

02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the face-to-face encounter requirements in Section 723 of these rules. (7-1-17)

03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (7-1-17)

04. Prior Authorizations. (7-1-17)

a. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (7-1-17)

i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. (7-1-17)

ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it. (7-1-17)

b. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. (7-1-17)

c. A valid prior authorization request is a written, faxed, or electronic request from a provider of Medicaid for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. (3-30-07)

05. Notification of Changes to Prior Authorization Requirements. The Department will provide sixty (60) days notice of any substantive and significant changes to requirements for prior authorization in its provider handbook. The Department will provide a method to allow providers to provide input and comment on proposed changes. (7-1-17)

06. Equipment Rental -- Purchase Procedures. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (7-1-17)

a. Rental payments, including intermittent payments, are to be automatically applied to the purchase

of the equipment. (3-30-07)

b. The Department may choose to continue to rent certain equipment without purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. (3-30-07)

c. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. (3-30-07)

07. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. Hearings will be conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (7-1-17)

754. (RESERVED)

755. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any participant's DME or medical supplies that are included in the per diem payment while such an individual is an inpatient in a hospital nursing facility or ICF/ID. (3-30-07)

02. Least Costly Limitation. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. (3-30-07)

03. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, the authorization number must be included on the claim form. (3-30-07)

04. Fees and Upper Limits. The Department will reimburse according to Section 230 of these rules. (3-30-07)

05. Date of Service. Unless specifically authorized by the Department the date of services for durable medical equipment and supplies is the date of delivery of the equipment or supply(s) for items provided in-person or the date of shipment for supplies mailed through a third-party courier. (3-13-20)T

06. Manually Priced Codes. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If the pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping, if that documentation is provided. (7-1-17)

07. Warranties and Cost of Repairs. No reimbursement will be made for the cost of repairs (materials or labor, or both) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: (7-1-17)

a. A power drive wheelchair must have a minimum one (1) year warranty period; (7-1-17)

b. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; (7-1-17)

c. All other wheelchairs must have a minimum one (1) year warranty period; (7-1-17)

d. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (7-1-17)

e. All other DME not specified in Subsections 755.07.a. through 755.07.d. of this rule must have a

minimum one (1) year warranty period; (7-1-17)

f. If the manufacturer denies the warranty due to user misuse or abuse, or both, that information must be forwarded to the Department at the time of the request for repair or replacement; (7-1-17)

g. The monthly rental payment must include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (7-1-17)

756. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: QUALITY ASSURANCE.
The use or provision of DME/medical supply items to an individual other than the participant for which such items were ordered is prohibited. The provision of DME/medical supply items that is not supported by required medical necessity documentation is prohibited and subject to recoupment. Violators are subject to penalties for program fraud or abuse, or both, that will be enforced by the Department. The Department has no obligation to repair or replace any piece of durable medical equipment that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the equipment. Participants suspected of the same will be reported to the Surveillance and Utilization Review (SUR/S) committee. (3-20-20)

757. -- 770. (RESERVED)

771. PROSTHETIC AND ORTHOTIC SERVICES: PARTICIPANT ELIGIBILITY.
The Medical Assistance Program will purchase or repair, or both, medically necessary prosthetic and orthotic devices and related services that artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by the Department. (3-20-20)

772. PROSTHETIC AND ORTHOTIC SERVICES: COVERAGE AND LIMITATIONS.

01. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services purchased by the Department: (3-30-07)

a. A temporary lower limb prosthesis will be purchased when documented by the attending physician that it is in the best interest of the participant's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable; (3-30-07)

b. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; (3-30-07)

c. All prosthetic and orthotic devices that require fitting must be provided by an individual who is certified or registered by the American Board for Certification in Orthotics or Prosthetics, or both; (3-20-20)

d. All equipment that is purchased must be new at the time of purchase. Modification to existing prosthetic or orthotic equipment, or both, will be covered by the Department; (3-20-20)

e. Prosthetic limbs purchased by the Department must be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the participant; (3-30-07)

f. Not more than ninety (90) days may elapse between the time the attending physician orders the equipment and the preauthorization request is presented to the Department for consideration; (3-30-07)

g. A reusable prosthetic or orthotic device purchased by the Department will remain the property of the Department and return of the device to the Department may be required when: (3-30-07)

i. The participant no longer requires the use of the device; or (3-30-07)

ii. The participant expires. (3-30-07)

02. Program Limitations. The following limitations apply to all prosthetic and orthotic services and equipment: (3-30-07)

a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and ordered by the attending physician; (3-30-07)

b. Refitting, repairs, or additional parts must be limited to once per calendar year for all prosthetics or orthotics, or both, unless it has been documented that a major medical change has occurred to the limb, and ordered by the attending physician; (3-20-20)

c. All refitting, repairs or alterations require preauthorization based on medical justification by the participant's attending physician; (3-30-07)

d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by the Department. (3-30-07)

e. Electronically powered or enhanced prosthetic devices are not covered; (3-30-07)

f. The Department will only authorize corrective shoes or modification to an existing shoe owned by the participant when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot; (3-30-07)

g. Shoes and accessories such as mismatch shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are not covered; and (3-30-07)

h. Corsets are not a benefit nor are canvas braces with plastic or metal bones. However, special braces enabling a participant to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast. (3-30-07)

773. PROSTHETIC AND ORTHOTIC SERVICES: PROCEDURAL REQUIREMENTS.
Prosthetic and orthotic devices and services will be paid for only if prescribed by a physician. The following information must be included in the physicians order and must be kept on file by the provider: (3-30-07)

01. Full Description of the Services Requested. A full description of the services requested; (3-30-07)

02. Number of Months the Equipment Will Be Needed and the Participant's Prognosis. Number of months the equipment will be needed and the participant's prognosis; (3-30-07)

03. Participant's Medical Diagnosis and Condition. The participant's medical diagnosis and the condition that requires the use of the prosthetic or orthotic services, or both, supplies, equipment or modifications, or both; and (3-20-20)

04. Modifications to the Prosthetic or Orthotic Device. All modifications to the prosthetic or orthotic device must be supported by the attending physician's description on the prescription. (3-30-07)

774. (RESERVED)

775. PROSTHETIC AND ORTHOTIC SERVICES: PROVIDER REIMBURSEMENT.
The Department will reimburse according to Section 230 of these rules. (3-30-07)

776. -- 779. (RESERVED)

SUB AREA: VISION SERVICES
(Sections 780-789)

780. -- 781. (RESERVED)

782. VISION SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies in accordance with the guidelines and limitations listed below. (3-30-07)

01. Eye Examinations. (3-29-12)

a. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period to determine the need for glasses to correct a refractive error. (3-29-12)

b. The Department will pay for eyeglasses within Department guidelines following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error. (3-29-12)

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. (3-20-20)

a. Scratch resistant coating is required for all plastic and polycarbonate lenses (3-30-07)

b. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department as defined in the Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. (3-20-20)

c. All contact lenses require prior authorization by the Department. Contact lenses will be covered for participants only with documentation of: (3-20-20)

i. A need for correction equal to or greater than plus or minus ten (±10) diopters; or (3-29-12)

ii. An extreme medical condition that does not allow correction through the use of conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other extreme conditions as defined by the Department. (3-29-12)

03. Replacement Lenses. Replacement lenses will be purchased for participants under the age of twenty-one (21) prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. Replacement lenses for participants age twenty-one (21) and older will be purchased when necessary to prevent permanent damage to the eye. (3-29-12)

04. Frames. Frames will be purchased according to the following guidelines: (3-30-07)

a. One (1) set of frames will be purchased by the Department for eligible participants not more often than once every four (4) years; (3-20-20)

b. When it is documented by the vision provider that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (3-29-12)

05. Fitting Fees. Fitting fees for either contact lenses or conventional frames and lenses are covered only when the participant is eligible under the Medicaid program guidelines to receive the supplies associated with the fitting fee. (3-29-12)

06. Non-Covered Items. A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary. (3-29-12)

a. Non-covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. (3-29-12)

b. Replacement of broken, lost, or missing glasses is the responsibility of the participant. (3-29-12)

783. -- 784. (RESERVED)

785. VISION SERVICES: PROVIDER REIMBURSEMENT.
All eyeglass frames and lenses provided to Medicaid participants and paid for by the Medicaid Program will be purchased from the supplier designated by the Department. (3-30-07)

786. -- 799. (RESERVED)

SUB AREA: DENTAL SERVICES
(Sections 800-819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
All participants eligible for Medicaid dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. (4-11-19)

801. DENTAL SERVICES: DEFINITIONS.
For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions apply: (3-29-12)

01. Adult. A person who is past the month of their twenty-first birthday. (3-29-12)

02. Child. A person from birth through the month of their twenty-first birthday. (3-29-12)

03. Idaho Smiles. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. (3-29-12)

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children and adults eligible for Medicaid are eligible for Idaho Smiles dental benefits described in Section 803 of these rules. (4-11-19)

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may be subject to limitations, authorization from the Idaho Smiles contractor or benefit restrictions according to the terms of its contract with the Department, in addition to those specified in these rules. (4-11-19)

01. Dental Coverage for Children. Children are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services (including root canals and crowns), periodontics, prosthodontic, orthodontic treatments, dentures, and oral surgery; (4-11-19)

02. Dental Limitation for Children. Orthodontics are limited to children who meet Medicaid eligibility requirements and the Idaho Medicaid Handicapping Malocclusion Index as determined by the State's contractor. (4-11-19)

03. Dental Coverage for Adults. Adults are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, periodontics, prosthodontic, dentures, oral surgery, and endodontic services with limitations. (4-11-19)

04. Dental Limitation for Adults. Root canals and crowns are not covered. (4-11-19)

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing

and quality assurance guidelines of the contractor. (3-29-12)

01. Administer Idaho Smiles. The contractor is responsible for administering the Idaho Smiles program, including dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (3-20-20)

02. Authorization. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. (3-29-12)

03. Grievances. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. (4-11-19)

04. Appeals. Appeals are handled by a process between the contractor and the Department as specified in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and in compliance with state and federal requirements. (4-11-19)

805. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (3-29-12)

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department-approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. (4-11-19)

807. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. (3-29-12)

808. -- 819. (RESERVED)

SUB AREA: ESSENTIAL PROVIDERS
(Sections 820-859)

820. RURAL HEALTH CLINIC (RHC) SERVICES.
A Rural Health Clinic is located in a rural area designated as a physician shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. (3-30-07)

821. -- 822. (RESERVED)

823. RURAL HEALTH CLINIC (RHC) SERVICES: COVERAGE AND LIMITATIONS.
RHC services are defined as follows: (3-30-07)

01. Physician Services. Physician services; (3-30-07)

02. Services and Supplies Incident to a Physician Service. Services and supplies incident to a physician service, which cannot be self administered; (3-30-07)

03. Physician Assistant Services. Physician assistant services; (3-30-07)

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; (3-30-07)

05. Clinical Psychologist Services. Clinical psychologist services; (3-30-07)

06. Clinical Social Worker Services. Clinical social worker services; (3-30-07)

07. Other Services and Supplies. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered by a physician service; or (3-30-07)

08. Home Health Agency Shortage Area Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. (3-30-07)

824. -- 825. (RESERVED)

826. RURAL HEALTH CLINIC (RHC) SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). (3-30-07)

02. RHC Encounter. An encounter, for RHC payment purposes, is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a provider as specified in 823.01 through 823.06 of these rules. (3-30-07)

a. Each contact with a separate discipline of health professional (medical or mental) on the same day at the same location is considered a separate encounter. (3-30-07)

b. Reimbursement for services is limited to two (2) encounters per participant per day. (3-30-07)

c. As an exception to Subsection 826.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or (3-30-07)

d. As an exception to Subsection 826.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (3-30-07)

e. A core service ordered by a health professional who did not perform the service but was performed by support staff is considered a single encounter. (3-30-07)

f. Multiple contacts with clinic staff of the same discipline (medical, mental) on the same day related to the same illness or injury are considered a single encounter. (3-30-07)

827. -- 829. (RESERVED)

830. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: DEFINITIONS.

01. Change in Intensity of Services of an FQHC. A change in the intensity of services of an FQHC means a change in the quantity and complexity of services delivered that could change an FQHC's total allowable cost per encounter. This does not include an expansion or remodeling of an existing FQHC. This may include such things as the addition of new services or the deletion of existing services. (4-2-08)

02. Encounter. An encounter, for FQHC payment purposes, is a face-to-face contact for the provision of medical/mental or dental services between a FQHC patient and a provider as specified in Subsections 832.01 through 832.07 of these rules. For the purposes of establishing encounter rates, the term “medical/mental” refers to a single category of service. (4-2-08)

03. Encounter Rate. An encounter rate can be of two (2) types, either medical/mental or dental; either of these two (2) types can be either an interim rate or a finalized rate. An encounter rate is the total amount of annual costs for the type of encounter divided by the total number of encounters for that type of encounter for the FQHC’s

fiscal year. (4-2-08)

a. Interim Encounter Rate. If the FQHC is new and historical cost information is not available, the Department sets the interim encounter rate using budgeted cost and encounter information submitted by the provider. If the FQHC is not able to obtain its financial budget information, the Department sets the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. (4-2-08)

b. Finalized Encounter Rate. If the FQHC is an existing facility and has at least twenty-four (24) consecutive months of historical cost and encounter information, the Department uses the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. (4-2-08)

04. Federally Qualified Health Centers (FQHCs). Federally qualified health centers are defined in federal law at 42 USC Section 1396d(1)(2), which incorporates the definition at 42 USC Section 1395x(aa)(1), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to medical assistance participants. (4-2-08)

05. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of an FQHC's costs. (4-2-08)

06. Medicare Economic Index (MEI). MEI is an annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice. The MEI takes into account cost categories such as a physician's own time, non-physician employees' compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used as part of the methodology for determining FQHC reimbursement rates. (4-2-08)

831. (RESERVED)

832. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: COVERAGE AND LIMITATIONS.
FQHC services are defined as follows: (3-30-07)

01. Physician Services. Physician services; or (3-30-07)

02. Incidental Services and Supplies to Physician Services. Services and supplies incidental to physician services, including drugs and pharmaceuticals that cannot be self-administered; or (3-30-07)

03. Physician Assistant Services. Physician assistant services; or (3-30-07)

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; or (3-30-07)

05. **Clinical Psychologist Services**. Clinical psychologist services; or (3-30-07)

06. Clinical Social Worker Services. Clinical social worker services; or (3-30-07)

07. Licensed Dentist and Dental Hygienist Services. Licensed dentist and dental hygienist services; or (3-30-07)

08. Incidental Services and Supplies to Non-Physicians. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, or dentist or dental hygienist services that would otherwise be covered if furnished by or incident to physician services; or (3-30-07)

09. FQHC Services. In the case of an FQHC that is located in an area that has a shortage of home

health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home-bound individual; and (3-30-07)

10. Other Payable Medical Assistance Ambulatory Services. Other payable medical assistance ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide, including pneumococcal or immunization vaccine and its administration. (3-30-07)

833. -- 834. (RESERVED)

835. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42 USC Section 1396a(bb), Subsections (1) through (4). (3-30-07)

02. FQHC Encounter Limitations and Exceptions. FQHC encounters have the following limitations and exceptions to these limitations as described in Subsections 835.02.a. through 835.02.d. of this rule: (4-2-08)

a. Each contact with a separate discipline of health professional (medical/mental or dental), on the same day at the same location, is considered a separate encounter. All contacts with all practitioners within a disciplinary category (medical/mental or dental) on the same day is one (1) encounter. (4-2-08)

b. Reimbursement for services is limited to three (3) encounters per participant per day. (3-30-07)

c. As an exception to Subsection 835.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or (4-2-08)

d. As an exception to Subsection 835.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (4-2-08)

836. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: RATE SETTING METHODOLOGY.

01. Prospective Payment System. (4-2-08)

a. For rate periods beginning on January 1, 2001, the Department will establish separate, finalized rates for medical/mental encounters and for dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. (4-2-08)

b. Beginning in federal fiscal year 2002, and for each federal fiscal year thereafter, the Department will pay each FQHC an encounter rate equal to the amount paid in the previous federal fiscal year. For the period starting with federal fiscal year 2002 and thereafter, the Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. For both medical/mental encounters and dental encounters, FQHCs are paid on a per encounter basis, with the limitations and exceptions described under Subsection 835.02 of these rules. (4-2-08)

c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined in Subsection 836.02.a. of this rule. If there is an increase in either the number of encounters or in the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined in Subsection 836.02.a. of this rule. (4-2-08)

02. FQHCs That Become Idaho Medicaid Providers. (4-2-08)

a. If the FQHC is new and encounter rate information for other FQHCs in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. If the FQHC is not able to provide its financial budget information, the Department will set the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. (4-2-08)

b. If the FQHC has been designated as an FQHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the FQHCs a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental FQHC encounters. (4-2-08)

c. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. (4-2-08)

d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with Subsection 836.01.b. of this rule. (4-2-08)

e. The Department will adjust the claim payments for all FQHC claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the FQHC for any total adjustment amount over what was reimbursed. The FQHC must pay the Department for any total adjustment amount that is under what was reimbursed. (4-2-08)

03. Change in an FQHC Encounter Rate Due to a Change in the FQHC's Scope of Services. (4-2-08)

a. After an FQHC obtains approval for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the FQHC must request the Department to review the encounter rate(s) for the FQHC. The review will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by an FQHC that could change an FQHC's total cost per encounter. The FQHC must request the Department to review the encounter rate(s) within sixty (60) days after the FQHC has gained approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. (4-2-08)

b. When an FQHC does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change the FQHC's scope of services, the FQHC must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s) for the FQHC. The Department will review the request for a change in intensity within 60 (sixty) days of the planned change in intensity of services. (4-2-08)

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when the FQHC has reported a change in scope of service. (4-2-08)

d. The Department will determine the encounter rate in accordance with Subsection 836.02 of this rule when the FQHC has reported a change in scope of service. The Department will audit and cost settle the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in an FQHC's scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be

recalculated and audited using the Medicare cost report for the second full twelve (12) month period. (4-2-08)

04. Annual Filing Requirements. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. (4-2-08)

05. Quarterly Supplemental Payments. In the case of any FQHC that contracts with a managed care organization, the Department will make quarterly supplemental payments to the FQHC for the difference between the payment amounts paid by the managed care organization and the amount to which the FQHC is entitled under the prospective payment system for Medicaid participants. (4-2-08)

837. -- 841. (RESERVED)

842. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: COVERAGE AND LIMITATIONS.
Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Subsection 835.02 of these rules. (3-30-07)

843. -- 844. (RESERVED)

845. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. (3-30-07)

02. Payment for Prescribed Drugs. Payment for prescribed drugs will be available as described in Subsection 662.01 of these rules. (3-30-07)

03. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (3-30-07)

04. Third Party Liability Not Applicable. The provisions of Section 215 of these rules are not applicable to Indian health service clinics. (3-30-07)

846. -- 849. (RESERVED)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting a participant'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. (3-20-20)

02. Children's Habilitation Intervention Services (CHIS). CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services. (3-13-20)T

03. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. (7-1-16)

04. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or

credentialed individuals trained in the evidence-based model. (3-20-20)

05. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who are not certified or credentialed in an evidence-based model. (3-20-20)

06. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology. or other areas of academic study as referenced in the Medicaid Provider Handbook. (3-20-20)

07. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-13)

08. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. http://www.psychrehabassociation.org. (7-1-16)

09. PRA Credential. Certificate or certification in psychiatric rehabilitation based upon the primary population with whom the individual works in accordance with the requirements set by the PRA. (7-1-19)

10. Practitioner of the Healing Arts. A physician's assistant, nurse practitioner, or clinical nurse specialist who is licensed and approved by the state of Idaho to make such recommendations or referrals for Medicaid services. (7-1-13)

11. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: (3-20-14)

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and (3-20-14)

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (3-20-14)

12. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (3-20-14)

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure: (3-20-20)

01. Medicaid Eligibility. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement; (3-20-20)

02. School Enrollment. Enrolled in an Idaho school district or charter school; (7-1-13)

03. Age. Twenty-one (21) years of age or younger and the semester in which their twenty-first birthday

falls is not finished; (3-30-07)

04. Educational Disability. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness." (7-1-13)

05. Parental Consent. Providers must obtain a one-time parental consent to access public benefits or insurance from a parent or legal guardian for school-based Medicaid reimbursement. (7-1-16)

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.
Skills Building/Community Based Rehabilitation Services (CBRS). Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. (7-1-19)

01. Skills Building/Community Based Rehabilitation Services (CBRS). To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: (7-1-19)

a. A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code. A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the school record. A Department-approved assessment must be used to obtain the child's initial functional impairment score. (3-13-20)T

b. A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: (7-1-16)

i. Vocational or educational; (3-20-20)

ii Financial; (3-20-14)

iii. Social relationships or support; (3-20-20)

iv. Family; (3-20-14)

v. Basic living skills; (3-20-14)

vi. Housing; (3-20-14)

vii. Community or legal; or (3-20-20)

viii. Health or medical. (3-20-20)

02. CHIS. Students eligible to receive habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services must have a standardized Department-approved assessment to identify functional, or behavioral needs, or both, that interfere with the student's ability to access an education or require intervention services to correct or ameliorate their condition in accordance with Section 880 of these rules. (3-20-20)

a. A functional need is determined when the student exhibits a deficit in an overall adaptive

composite or deficits in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. A deficit is defined as one point five (1.5) or more standard deviations below the mean for all functional areas. (3-20-20)

b. A behavioral need is determined when the student exhibits maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by a rater familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by a rater familiar with the student, on a standardized behavioral assessment approved by the Department. (3-20-20)

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. (7-1-16)

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (7-1-13)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-30-07)

a. Vocational Services. (3-30-07)

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (3-30-07)

c. Recreational Services. (3-30-07)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (7-1-16)

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-30-07)

a. Be recommended or referred by a physician or other practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral; (3-28-18)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; (3-20-14)

c. Be directed toward a diagnosis; (7-1-16)

d. Include recommended interventions to address each need; and (7-1-16)

e. Include name, title, and signature of the person conducting the evaluation. (7-1-16)

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral. (3-13-20)T

a. Behavioral Intervention. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan with the purpose of preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) students. (3-13-20)T

ii. As the number and severity of the students with behavioral issues increases, the student ratio in the group must be adjusted accordingly. (3-13-20)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-20-20)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (7-1-13)

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-13)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (7-1-13)

c. Crisis Intervention. Crisis intervention services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. This service is provided on a short-term basis typically not to exceed thirty (30) school days and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following: (3-20-20)

i. Hospitalization; (3-20-20)

ii. Out-of-home placement; (3-20-20)

iii. Incarceration; or (3-20-20)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-20-20)

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions. (3-20-20)

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) students. (3-13-20)T

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted accordingly. (3-13-20)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-20-20)

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional. (3-20-20)

f. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician, and prior authorized. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (7-1-16)

g. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his or her practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-16)

h. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-30-07)

i. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. Personal care services do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: (7-1-16)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (7-1-13)

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; (7-1-16)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-13)

iv. Assisting the student with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, “Rules of the Idaho Board of Nursing,” Subsection 490.05; (7-1-13)

v. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and the requirements are met in accordance with IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Subsection 303.01. (7-1-13)

j. Physical Therapy and Evaluation. (3-30-07)

k. Psychological Evaluation. (3-30-07)

l. Psychotherapy. (3-30-07)

m. Skills Building/Community Based Rehabilitation Services (CBRS). Skills Building/CBRS are interventions to reduce the student’s disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills. These services are intended to prevent placement of the student into a more restrictive educational situation. (7-1-19)

n. Speech/Audiological Therapy and Evaluation. (3-30-07)

o. Social History and Evaluation. (3-30-07)

p. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home and school when: (7-1-16)

i. The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student; (3-28-18)

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. (3-20-14)

q. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. (7-1-16)

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of five (5) years: (7-1-16)

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP) defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed indicating the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the school district or charter school is requesting reimbursement. The IEP and transitional IFSP must include: (3-13-20)T

a. Type, frequency, and duration of the service(s) provided; (7-1-13)

b. Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)

c. Measurable goals, when goals are required for the service; and (7-1-13)

d. Specific place of service, if provided in a location other than school. (7-1-16)

02. **Evaluations and Assessments**. Evaluations and assessments must: (3-20-20)

a. Support services billed to Medicaid; and (3-13-20)T

b. Accurately reflect the student's current status. (3-13-20)T

03. **Service Detail Reports**. A service detail report that includes: (7-1-13)

a. Name of student; (7-1-13)

b. Name, title, and signature of the person providing the service; (7-1-16)

c. Date, time, and duration of service; (7-1-13)

d. Place of service, if provided in a location other than school; (7-1-13)

e. Category of service and brief description of the specific areas addressed; and (7-1-13)

f. Student's response to the service when required for the service. (7-1-13)

04. **Review**. A documented review of progress toward each service plan goal. (3-13-20)T

05. **Documentation of Qualifications of Providers**. (7-1-13)

06. **Copies of Required Referrals and Recommendations**. Copies of required referrals and recommendations. (7-1-13)

a. School-based services must be recommended or referred by a physician or other practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement. (7-1-13)

b. A recommendation or referral must be obtained within thirty (30) days of the provision of services for which the school district or charter school is seeking reimbursement. Therapy requirements for the physician's order are identified in Section 733 of these rules. (3-28-18)

07. **Parental Notification**. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.08 of this rule. (3-20-14)

08. **Requirements for Cooperation with and Notification of Parents and Agencies**. Each school district or charter school billing for Medicaid services must act in cooperation with students' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. (7-1-16)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must document that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must document that they provided the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (7-1-16)

b. Primary Care Physician (PCP). School districts and charter schools must request the name of the student's primary care physician and request a written consent to release and obtain information between the PCP and the school from the parent or guardian. (7-1-16)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (7-1-13)

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)

01. Behavioral Intervention. Behavioral intervention must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: (3-20-20)

a. Intervention Paraprofessional. Intervention paraprofessionals may provide direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: (3-13-20)T

i. Be at least eighteen (18) years of age; (3-20-20)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and (3-20-20)

iii. Meet the paraprofessional requirements as defined in IDAPA 08.02.02, "Rules Governing Uniformity." (3-20-20)

b. Intervention Technician. Intervention technician is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must: (3-13-20)T

i. Be an individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-20-20)

ii. Hold a bachelor's degree from an accredited institution in a human services field or a has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. (3-20-20)

c. Intervention Specialist. Intervention specialists may provide direct services, complete assessments, and develop implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (3-20-20)

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, "Rules Governing Uniformity," Sections 021-024; or (3-20-20)

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, and does not have a gap of more than three (3) years of employment as an intervention specialist, or (3-20-20)

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (3-20-20)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; (3-20-20)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-20-20)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-20-20)

d. Intervention Professional. Intervention professionals may provide direct services, complete assessments, and develop implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (3-20-20)

i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-20-20)

ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-20-20)

e. Evidence-Based Model (EBM) Intervention Paraprofessional. EBM intervention paraprofessionals may provide direct services. EBM intervention paraprofessionals must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must: (3-20-20)

i. Hold a high school diploma; and (3-20-20)

ii. Hold a para-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

f. Evidence- Based Model (EBM) Intervention Specialist. EBM intervention specialists may provide direct services, complete assessments, and develop implementation plans. EBM intervention specialists must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must: (3-20-20)

i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-20-20)

ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department. (3-13-20)T

g. Evidence-Based Model (EBM) Intervention Professional. EBM intervention professionals may provide direct services, complete assessments, and develop implementation plans. EBM intervention professionals may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. An EBM intervention professional must: (3-20-20)

i. Hold a master's degree or higher from an accredited institution in accordance with their

certification or credentialing requirements; and (3-20-20)

ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department. (3-20-20)

02. Behavioral Consultation. Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: (3-20-20)

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, "Rules Governing Uniformity"; (3-20-20)

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," excluding a licensed registered nurse or audiologist; (3-20-20)

c. An occupational therapist who is qualified and registered to practice in Idaho; (3-20-20)

d. An intervention professional, as defined in Subsection 855.01 of this rule; or (3-20-20)

e. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-13-20)T

03. Crisis Intervention. Crisis intervention must be provided by, or under the supervision of an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: (3-20-20)

a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)

b. An intervention technician, as defined in Subsection 855.01 of this rule; (3-20-20)

c. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

d. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)

e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)

f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

g. An EBM intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)

h. A licensed physician, licensed practitioner of the healing arts; (3-20-20)

i. An advanced practice registered nurse; (3-20-20)

j. A licensed psychologist; (3-20-20)

k. A licensed clinical professional counselor or professional counselor; (3-20-20)

l. A licensed marriage and family therapist; (3-20-20)

m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-20-20)

n. A psychologist extender registered with the Bureau of Occupational Licenses; (3-20-20)

o. A licensed registered nurse (RN); (3-20-20)

p. A licensed occupational therapist; or (3-20-20)

q. An endorsed or certified school psychologist. (3-20-20)

04. Habilitative Skill Building. Habilitative skill building must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following: (3-20-20)

a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)

b. An intervention technician, as defined in Subsection 855.01 of this rule; (3-20-20)

c. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

d. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)

e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; (3-20-20)

f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; or (3-20-20)

g. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-20-20)

05. Interdisciplinary Training. Interdisciplinary Training must be provided by one (1) of the following: (3-20-20)

a. An intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

b. An intervention professional, as defined in Subsection 855.01 of this rule; (3-20-20)

c. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; (3-20-20)

d. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-20-20)

06. Medical Equipment and Supplies. See Subsection 853.03 of these rules. (3-20-14)

07. Nursing Services. Nursing services must be provided by a licensed registered nurse (RN) or by a licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-13)

08. Occupational Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)

09. Personal Care Services. Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. (7-1-13)

a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-13)

i. Licensed Registered Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse; (7-1-13)

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; (7-1-16)

iii. Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or (7-1-16)

iv. 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. (4-11-19)

b. The licensed registered nurse (RN) must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care. Oversight provided by the RN must include all of the following: (3-13-20)T

i. Development of the written PCS plan of care; (7-1-13)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (7-1-16)

iii. Reevaluation of the plan of care as necessary. (3-13-20)T

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (7-1-16)

10. **Physical Therapy and Evaluation**. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)

11. **Psychological Evaluation**. A psychological evaluation must be provided by a: (7-1-13)

a. Licensed psychiatrist; (7-1-13)

b. Licensed physician; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-13)

e. Endorsed or certified school psychologist. (7-1-16)

12. **Psychotherapy**. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-13)

a. Psychiatrist, M.D.; (7-1-13)

b. Physician, M.D.; (7-1-13)

c. Licensed psychologist; (7-1-13)

d. Licensed clinical social worker; (7-1-13)

e. Licensed clinical professional counselor; (7-1-13)

f. Licensed marriage and family therapist; (7-1-13)

g. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (7-1-13)

h. Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (7-1-13)

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (7-1-13)

j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised

as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (7-1-13)

k. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-13)

13. Skills Building/Community Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following. Skills Building/Community Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following: (3-13-20)T

a. Licensed physician, licensed practitioner of the healing arts; (7-1-16)

b. Advanced practice registered nurse; (7-1-16)

c. Licensed psychologist; (7-1-13)

d. Licensed clinical professional counselor or professional counselor; (7-1-13)

e. Licensed marriage and family therapist; (7-1-16)

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-13)

g. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-13)

h. Licensed registered nurse (RN); (7-1-13)

i. Licensed occupational therapist; (7-1-13)

j. Endorsed or certified school psychologist; (7-1-16)

k. Skills Building/Community Based Rehabilitation Services specialist. A Skills Building/CBRS specialist must: (7-1-19)

i. Be an individual who has a bachelor's degree and holds a current PRA credential; or (7-1-19)

ii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist to review treatment provided to student participants on an ongoing basis. The frequency of the one-to-one (1:1) supervision must occur at least monthly. Supervision can be conducted using telehealth when it is equally effective as direct on-site supervision; and (3-13-20)T

iii. Have a credential required for CBRS specialists. (7-1-19)

14. Speech/Audiological Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-16)

15. Social History and Evaluation. Social history and evaluation must be provided by a licensed registered nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (7-1-13)

16. Transportation. Transportation must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-13)

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The

services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. (7-1-16)

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (7-1-16)

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision and service requirements. (7-1-16)

c. Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. (7-1-16)

i. Supervision must be provided by an SLP professional as defined in Section 734 of this chapter of rules. (7-1-16)

ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. (3-20-20)

856. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts and charter schools must be in accordance with rates established by the Department. (7-1-13)

01. Payment in Full. Providers of services must accept as payment in full the school district or charter school payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (7-1-13)

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (3-30-07)

03. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-30-07)

04. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-30-07)

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (3-30-07)

b. School districts and charter schools will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (3-30-07)

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (3-30-07)

d. The payments to the districts will include both the federal and non-federal share (matching funds). (3-30-07)

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (3-30-07)

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (3-30-07)

g. The Department will provide the school districts a monthly statement that will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (3-30-07)

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (3-30-07)

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (3-30-07)

857. SCHOOL-BASED SERVICE: QUALITY ASSURANCE AND IMPROVEMENT.
The provider will grant the Department immediate access to all information required to review compliance with these rules. (7-1-16)

01. Quality Assurance. Quality Assurance consists of reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. (7-1-16)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. (7-1-16)

858. -- 859. (RESERVED)

SUB AREA: MEDICAL TRANSPORTATION SERVICES
(Sections 860-879)

860. (RESERVED)

861. EMERGENCY TRANSPORTATION SERVICES: PARTICIPANT ELIGIBILITY.
Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms or signs, or both, which, by reasonable medical judgment of the Department, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. (3-20-20)

862. EMERGENCY TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Prior Authorization. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department. (3-30-07)

02. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department. (3-30-07)

03. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (3-30-07)

a. The point of pickup is inaccessible by land vehicle; or (3-30-07)

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and (3-30-07)

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (3-30-07)

04. Co-Payments. When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment amount as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (4-2-08)

863. EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.

01. Services Subject to Review. Ambulance services are subject to review by the Department prior to the service being rendered, and on a retrospective basis. (3-30-07)

02. Non-Emergency Transport Prior Authorization Required. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department. (3-30-07)

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. (3-30-07)

864. EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Medically Necessary. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department that travel by ambulance is medically necessary due to the medical condition of the participant, and that any other mode of travel would, by reasonable medical judgment of the Department, result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. (3-20-20)

02. Licensure Required. All Emergency Medical Services (EMS) Providers that provide services to Medicaid participants in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements," and IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements." Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (3-20-20)

03. Usual Charges. Ambulance services providers cannot charge Medicaid participants more than is charged to the general public for the same service. (3-30-07)

04. Air Ambulance. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the participant. (3-30-07)

865. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.

01. Scope of Coverage and General Requirements for Ambulance Services. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory

Rulings." Payment for ambulance services is subject to the following limitations: (3-30-07)

02. Ambulance Reimbursement. (3-30-07)

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. (3-30-07)

b. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. (3-30-07)

c. If a physician is in attendance during transport, they are responsible for the billing of their services. (3-30-07)

d. Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (3-30-07)

e. Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintain. At least this level of personnel is required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the following: (3-30-07)

i. The level of personnel required to be in the patient compartment of the ambulance; (3-30-07)

ii. The level of ambulance license the unit has been issued; and (3-30-07)

iii. The level of life support authorized by the Department. (3-30-07)

f. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. (3-30-07)

g. If multiple licensed EMS providers are involved in the transport of a participant, only the ambulance provider who actually transports the participant will be reimbursed for the services. (3-20-20)

i. In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. (3-20-20)

ii. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. (3-20-20)

iii. In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALSI, ALSII, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the participant during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department. (3-20-20)

iv. The ground ambulance provider may also bill for their part of the trip as authorized by the Department. (3-20-20)

h. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage, as authorized by the Department. (3-30-07)

i. If a licensed transporting EMS provider responds to an emergency situation and treats the participant, but does not transport the participant, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate. This service requires authorization from the Department, usually on a retrospective basis. (3-30-07)

j. If an ambulance vehicle and crew have returned to a base station after having transported a participant to a facility and the participant's physician orders the participant to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (3-30-07)

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the participant is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (3-30-07)

l. If a licensed transporting EMS provider responds to a participant's location and upon examination and evaluation of the participant, finds that their condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. (3-30-07)

866. -- 869. (RESERVED)

870. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DEFINITIONS.
For the purposes of Sections 870 through 879 of these rules, the following definitions apply. (4-7-11)

01. Contracted Transportation Provider. A non-emergency medical transportation provider who is under contract with the transportation broker to provide non-emergency medical transportation for Medicaid participants. (4-7-11)

02. Individual Contracted Transportation Provider. An individual who is under contract with the transportation broker to provide non-emergency medical transportation for a Medicaid participant in the provider's personal vehicle. (4-7-11)

03. Non-Emergency Medical Transportation. Non-emergency medical transportation is transportation that is: (4-7-11)

a. Not of an emergency nature; and (4-7-11)

b. Required for a Medicaid participant to access medically necessary services covered by Medicaid when the participant's own transportation resources, family transportation resources, or community transportation resources do not allow the participant to reach those services. (4-7-11)

04. Transportation Broker. An entity under contract with the Department to administer, coordinate, and manage a statewide network of non-emergency medical transportation providers. (4-7-11)

05. Travel-Related Services. Travel-related services are meals, lodging, and attendant care required for non-emergency medical transportation to be completed for a Medicaid participant. (4-7-11)

871. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DUTIES OF THE TRANSPORTATION BROKER.
The transportation broker under contract with the Department is required to: (4-7-11)

01. Coordinate and Manage. Coordinate and manage all non-emergency medical transportation services for Medicaid participants statewide. (4-7-11)

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide non-emergency medical transportation services for Medicaid participants. (4-7-11)

03. Call Center. Operate a call center to receive and review non-emergency medical transportation for Medicaid participants meeting the requirements in Section 872 of these rules. (4-7-11)

04. Authorize Non-Emergency Medical Transportation Services. Authorize non-emergency medical transportation services for Medicaid participants requesting transportation and who meet the requirements in Section 872 of these rules. (4-7-11)

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for non-emergency medical transportation services meeting the requirements in Section 872 of these rules. (4-7-11)

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver non-emergency medical transportation services in a safe and professional manner. (4-7-11)

872. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Non-Emergency Medical Transportation Services. The transportation broker will reimburse contracted transportation providers for non-emergency medical transportation services under the following conditions: (4-7-11)

a. The travel is essential to get to or from a medically necessary Medicaid covered service; (4-7-11)

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; (4-7-11)

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; (4-7-11)

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; (4-7-11)

e. The travel is authorized and scheduled by the transportation broker; and (4-7-11)

f. The contracted transportation provider is in compliance with the terms of its contract with the transportation broker. (4-7-11)

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: (4-7-11)

a. The reasonable cost of meals actually incurred in transit will be reimbursed for the participant when there is no other practical means of obtaining food. (4-7-11)

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: (4-7-11)

i. The round trip and the needed medical service cannot be completed in the same day; and (4-7-11)

ii. No less costly alternative is available. (4-7-11)

c. The reasonable cost of wages for an attendant will be reimbursed when: (4-7-11)

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (4-7-11)

ii. No family member or other unpaid attendant is available to accompany the participant. (4-7-11)

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: (4-7-11)

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (4-7-11)

ii. There is no other practical means of obtaining food. (4-7-11)

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: (4-7-11)

i. An overnight stay is required to receive the service; (4-7-11)

ii. It is medically necessary or the vulnerability of the participant requires accompaniment for safety; and (4-7-11)

iii. No less costly alternative is available. (4-7-11)

873. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: REIMBURSEMENT METHODOLOGY.
The Department will reimburse the NEMT services broker a fixed, actuarially sound amount per member per month based on the cost of efficiently delivered, timely, and safe non-emergency medical transportation for eligible Idaho Medicaid participants and the cost for efficient administration of the brokerage program. (4-11-19)

874. -- 879. (RESERVED)

SUB AREA: EPSDT SERVICES
(Sections 880-889)

880. EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES: DEFINITION.
Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of medical practice. (4-4-13)

881. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: PARTICIPANT ELIGIBILITY.
EPSDT services are available to child participants from birth through the month of their twenty-first birthday. (3-30-07)

882. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: COVERAGE AND LIMITATIONS.

01. Additional Services. Any service required as a result of an EPSDT screen and which is currently

covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. (3-30-07)

02. Medically Necessary. The need for additional services must be documented by the attending physician as medically necessary. (3-20-20)

03. Prior Authorization. Any service requested, that is covered under Title XIX or Title XXI of the Social Security Act, that is not identified in these rules specifically as a Medicaid-covered service will require prior authorization prior to payment for that service. (3-30-07)

04. Services Not Covered. The Department will not cover services for cosmetic, convenience, or comfort reasons. (3-30-07)

05. Hearing Aids Under EPSDT. (3-30-07)

a. When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (3-30-07)

b. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 742.01.a., 742.01.b., and 742.03 are met. (4-2-08)

c. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist. (3-30-07)

06. Eyeglasses Under EPSDT. (3-30-07)

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. (3-30-07)

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (3-30-07)

883. -- 889. (RESERVED)

SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 890-899)

890. PREGNANCY-RELATED SERVICES: DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems that may adversely affect the outcome of the pregnancy. (3-30-07)

02. Maternity Nursing Visit. Office visits by a licensed registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. (3-30-07)

03. Nursing Services. Home visits by a licensed registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. (3-30-07)

04. Nutritional Services. Nutritional services are described in Sections 630 through 635 of these rules. (3-30-07)

05. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. (3-30-07)

891. (RESERVED)

892. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.
When ordered by the participant's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. (3-30-07)

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (3-30-07)

02. Maternity Nursing Visit. These services are only available to women unable to obtain a physician, NP, PA, or NM to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. (3-30-07)

03. Nursing Services. Limited to two (2) visits during the covered period. (3-30-07)

04. Nutrition Services. Nutritional services are described in Sections 630 through 632 of these rules. (3-30-07)

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. (3-30-07)

893. PREGNANCY-RELATED SERVICES: PROCEDURAL REQUIREMENTS.
Pregnancy-related services described in Sections 890 through 892 of these rules must be prior authorized by the Department. (3-30-07)

894. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Services must be: (3-20-20)

01. Risk Reduction Follow-Up. Provided by licensed social workers, licensed registered nurses, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities that have current provider agreements with the Department. (3-20-20)

02. Individual and Family Social Services. Provided by a licensed social worker qualified to provide individual counseling in accordance with the provisions of IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (3-20-20)

895. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.

01. Rates. Rate of payment for pregnancy-related services is established under the provisions of Section 230 of these rules. (3-30-07)

02. Risk Reduction Followup Services. A single payment will be made for each month of service provided. (3-30-07)

896. -- 899. (RESERVED)

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 900 - 999)

SUB AREA: LIENS AND ESTATE RECOVERY
(Sections 900-909)

900. LIENS AND ESTATE RECOVERY.

In accordance with Sections 55-819, 56-218, 56-218A, and 56-225, Idaho Code, this Section of rule sets forth the provisions for recovery of medical assistance, the filing of liens against the property of deceased persons, the filing of liens against the property of permanently institutionalized participants, and the recording of requests for notice. (4-7-11)

01. Medical Assistance Incorrectly Paid. The Department may, in accordance with a judgment of a court, file a lien against the property of a living or deceased person of any age to recover the costs of medical assistance incorrectly paid. (3-20-20)

02. Administrative Appeals. Permanent institutionalization determination, undue hardship waiver, and request for notice hearings are governed by the fair hearing provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (4-7-11)

901. LIENS AND ESTATE RECOVERY: DEFINITIONS.
The following terms are applicable to Sections 900 through 909 of these rules: (4-7-11)

01. Authorized Representative. The person appointed by the court as the personal representative in a probate proceeding or, if none, the person identified by the participant to receive notice and make decisions on estate matters. (3-30-07)

02. Discharge From a Medical Institution. A medical decision made by a competent medical professional that the Medicaid participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated. (3-30-07)

03. Equity Interest in a Home. Any equity interest in real property recognized under Idaho law. (3-30-07)

04. Estate. All real and personal property and other assets including those in which the participant had any legal or beneficial title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assignee of the deceased participant through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. (3-30-07)

05. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as their primary dwelling prior to, or subsequent to, their admission to a medical institution. (3-30-07)

06. Institutionalized Participant. An inpatient in a nursing facility (NF), intermediate care facility for people with intellectual disabilities (ICF/ID), or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-30-07)

07. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (3-30-07)

08. Permanently Institutionalized. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent medical professional that the participant is physically able to leave the institution and return to live at home. (3-30-07)

09. Personal Property. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. (3-30-07)

10. Real Property. Any land, including buildings or immovable objects attached permanently to the land. (3-30-07)

11. Residing in the Home on a Continuous Basis. Occupying the home as the primary dwelling and continuing to occupy such dwelling as the primary residence. (3-30-07)

12. Termination of a Lien. The release or dissolution of a lien from property. (3-30-07)

13. Undue Hardship. Conditions that justify waiver of all or a part of the Department's claim against an estate, described in Subsections 905.06 through 905.10 of these rules. (4-7-11)

14. Undue Hardship Waiver. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. (3-30-07)

902. LIENS AND ESTATE RECOVERY - NOTIFICATION TO DEPARTMENT.
All notification regarding liens, estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 3272 Elder, Suite B, P.O. Box 83720, Boise, Idaho, 83720-0009. (4-7-11)

903. LIENS AND ESTATE RECOVERY: LIEN DURING LIFETIME OF PARTICIPANT.

01. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, and subject to the restrictions set forth in Subsection 903.04 of this rule, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on their behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization, but not before July 1, 1995. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. (4-7-11)

02. Determination of Permanent Institutionalization. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of Home and Community Based Services does not, in and of itself, justify a decision that they are reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: (3-30-07)

a. The participant must meet the criteria for nursing facility or ICF/ID level of care and services as set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 220 through 299, and 580 through 649; (3-30-07)

b. The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that they will not require nursing facility or ICF/D level of care; and (3-30-07)

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information, or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. (3-30-07)

03. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or their authorized representative, in writing, of its intention to make a determination that the participant is permanently institutionalized, and that they have the right to a fair hearing in accordance with Subsection 900.02 of these rules. This notice must inform the participant of the following information, at a minimum: (4-7-11)

a. The Department's decision that they cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude them from returning home with services necessary to support nursing facility or ICF/ID level of care; and (4-7-11)

b. They or their authorized representative may request a fair hearing prior to the Department's final determination that they are permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. (4-7-11)

c. If they or their authorized representative does not request a fair hearing within the time limits specified, their real property, including their home, may be subject to a lien, contingent upon the restrictions in

Subsection 903.04 of this rule. (4-7-11)

04. Restrictions on Imposing Lien During Lifetime of Participant. A lien may be imposed on the participant's real property; however, no lien may be imposed on the participant's home if any of the following is lawfully residing in such home: (3-30-07)

a. The spouse of the participant; (3-30-07)

b. The participant's child who is under age twenty-one (21), or who is blind or disabled as defined in 42 U.S.C. 1382c as amended; or (3-30-07)

c. A sibling of the participant who has an equity interest in the participant's home and who was residing in such home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution, and who has been residing in the home on a continuous basis. (3-30-07)

05. Restrictions on Recovery on Lien Imposed During Lifetime of Participant. Recovery will be made on the lien from the participant's estate, or at any time upon the sale of the property subject to the lien, but only after the death of the participant's surviving spouse, if any, and only at a time when: (3-30-07)

a. The participant has no surviving child who is under age twenty-one (21); (3-30-07)

b. The participant has no surviving child of any age who is blind or disabled as defined in 42 U.S.C. 1382c as amended; and (3-30-07)

c. In the case of a lien on a participant's home, when none of the following is lawfully residing in such home who has lawfully resided in the home on a continuous basis since the date of the participant's admission to the medical institution: (3-30-07)

i. A sibling of the participant, who was residing in the participant's home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution; or (3-30-07)

ii. A son or daughter of the participant, who was residing in the participant's home for a period of at least two (2) years immediately before the date of the participant's admission to the medical institution, and who establishes by a preponderance of the evidence that they provided necessary care to the participant, and the care they provided allowed the participant to remain at home rather than in a medical institution. (3-30-07)

06. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant. Should the property upon which a lien is imposed be sold prior to the participant's death, the Department will seek recovery of all medical assistance paid on behalf of the participant, subject to the restrictions in Subsection 903.05 of this rule. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate as described in Subsection 904.01 of these rules. (4-7-11)

07. Filing of Lien During Lifetime of Participant. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: (3-30-07)

a. The name and last known address of the participant; and (3-30-07)

b. The name and address of the official or agent of the Department filing the lien; and (3-30-07)

c. A brief description of the medical assistance received by the participant; and (3-30-07)

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. (3-30-07)

08. Renewal of Lien Imposed During Lifetime of Participant. The lien, or any extension thereof,

must be renewed every five (5) years by filing a new verified statement as required in Subsection 903.07 of this rule, or as required by Idaho law. (4-7-11)

09. Termination of Lien Imposed During Lifetime of Participant. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt and the estate remains subject to recovery under estate recovery provisions in Sections 904 and 905 of these rules. (4-7-11)

904. LIENS AND ESTATE RECOVERY: REQUIREMENTS FOR ESTATE RECOVERY.

01. Estate Recovery Requirements. In accordance Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: (4-7-11)

a. The costs of all medical assistance correctly paid on or after July 1, 1995, on behalf of a participant who was permanently institutionalized; (3-30-07)

b. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age fifty-five (55) or older on or after July 1, 1994; and (3-30-07)

c. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age sixty-five (65) or older on or after July 1, 1988. (3-30-07)

02. Recovery From Estate of Spouse. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and 56-218A, Idaho Code. (3-30-07)

03. Lien Imposed Against Estate of Deceased Participant. Liens may be imposed against the estates of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. (3-30-07)

04. Notice of Estate Claim. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. (3-30-07)

05. Assets in Estate Subject to Claims. The authorized representative will be notified of the Department's claim against the assets of a deceased participant. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which they had an ownership interest, including the following: (3-30-07)

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. (3-30-07)

b. The deceased participant's ownership interest in an estate, probated or not probated, is an asset of their estate when: (3-30-07)

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (3-30-07)

ii. The deceased participant received income from property of another person; or (3-30-07)

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. (3-30-07)

c. Any trust instrument that is designed to hold or to distribute funds or property, real or personal, in

which the deceased participant had a beneficial interest is an asset of the estate. (3-30-07)

d. Life insurance is considered an asset when it has reverted to the estate. (3-30-07)

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. (3-30-07)

f. Checking and savings accounts that hold and accumulate funds designated for the deceased participant, are assets of the estate, including joint accounts that accumulate funds for the benefit of the participant. (3-30-07)

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to their death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. (3-30-07)

h. Shares of stocks, bonds and mutual funds to the benefit of the deceased participant are assets of the estate. The current market value of all stocks, bonds and mutual funds must be proved as of the month preceding settlement of the estate claim. (3-30-07)

06. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. (3-30-07)

905. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

01. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. Recovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and, when applicable, as provided in Subsection 903.05 of these rules. No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. (4-7-11)

02. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: (3-30-07)

a. Burial expenses, which include only those reasonably necessary for embalming, transportation of the body, cremation, flowers, clothing, and services of the funeral director and staff may be deducted. (3-30-07)

b. Other legally enforceable and necessary debts with priority may be deducted. The Department's claim is classified and paid as a debt with preference as defined in Section 15-03-805, Idaho Code. Debts of the deceased participant that may be deducted from the estate prior to satisfaction of the Department's claim must be legally enforceable debts given preference over the Department's claim under Section 15-03-805, Idaho Code. (3-30-07)

03. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. (3-30-07)

04. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (3-30-07)

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant or their spouse will not be subject to estate recovery if: (4-4-13)

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or (4-4-13)

b. The life estate was created prior to July 1, 1995. (4-4-13)

06. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement that separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (3-30-07)

07. Release of Estate Claims. The Department will release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: (3-30-07)

a. When an undue hardship waiver as defined in Subsection 905.07 of this rule has been granted; or (4-7-11)

b. When a written agreement with the authorized representative to pay the Department's claim in thirty-six (36) monthly payments or less has been achieved. (3-30-07)

08. Purpose of the Undue Hardship Exception. The undue hardship exception is intended to avoid the impoverishment of the deceased participant's family due to the Department exercising its estate recovery right. The fact that family members anticipate or expect an inheritance, or will be inconvenienced economically by the lack of an inheritance, is not cause for the Department to declare an undue hardship. (3-30-07)

09. Application for Undue Hardship Waiver. An applicant for an undue hardship waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (3-30-07)

10. Basis for Undue Hardship Waiver. Undue hardship waivers will be considered in the following circumstances: (3-30-07)

a. The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or (3-30-07)

b. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (3-30-07)

c. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. (3-30-07)

d. The participant received medical assistance as the result of a crime committed against the participant. (3-30-07)

11. Limitations on Undue Hardship Waiver. Any beneficiary of the estate of a deceased participant may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case by case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. (3-30-07)

12. Set Aside of Transfers. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether or not the asset transfer resulted, or could have resulted, in a period of ineligibility. (3-30-07)

906. LIENS AND ESTATE RECOVERY: REQUEST FOR NOTICE.

01. Request for Notice - Notice - Hearing. The Department must notify the participant or their authorized representative, in writing, of its intention to record a request for notice, and that they have the right to a fair hearing in accordance with Subsection 900.02 of these rules. The notice must inform the participant of the following information, at a minimum: (4-7-11)

a. The Department's determination that they are the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; (4-7-11)

b. They or their authorized representative may request a fair hearing prior to the Department's recording a request for notice. The notice must include the time limits and instructions for requesting a fair hearing; and (4-7-11)

c. If they or their authorized representative do not request a fair hearing within the time limits specified, a request for notice applying to their real property, including their home, may be recorded. (4-7-11)

02. Request for Notice - Forms - Content. The notices must include, at a minimum, the following information: (4-7-11)

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; (4-7-11)

b. The Medicaid number for the public assistance recipient and spouse, if any; (4-7-11)

c. The legal description of the real property affected or to be affected; (4-7-11)

d. The mailing address at which the Department is to receive notice as provided in Section 902 of these rules; (4-7-11)

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and (4-7-11)

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. (4-7-11)

03. Webpages for Forms. The forms may be found at: (4-7-11)

a. Notice of Transfer or Encumbrance at http://healthandwelfare.idaho.gov. (4-7-11)

b. Request for Notice at http://healthandwelfare.idaho.gov. (4-7-11)

c. Termination of Request for Notice at http://healthandwelfare.idaho.gov. (4-7-11)

907. -- 909. (RESERVED)

SUB AREA: PARTICIPANT LOCK-IN
(Sections 910 - 918)

910. PARTICIPANT UTILIZATION CONTROL PROGRAM.
This Program is designed to promote improved and cost-efficient medical management of essential health care by monitoring participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization or exceeding reasonable levels of utilization, or both, will be reviewed for restriction. The Department may require a participant to designate a primary physician or a single pharmacy or both for exclusive provider services in an effort to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance, and avoid excessive utilization of prescription medications. (3-20-20)

911. LOCK-IN DEFINED.

Lock-in is the process of restricting the access of a participant to a specific provider or providers. (3-30-07)

912. DEPARTMENT EVALUATION FOR LOCK-IN.
The Department will review participants to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services that is not medically necessary. Evaluation of utilization patterns can include review by the Department staff of medical records or computerized reports, or both, generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab or diagnostic procedures, or both, hospital admissions, and referrals. (3-20-20)

913. CRITERIA FOR LOCK-IN.
Since it is impossible to identify all possible patterns of over utilization, and since a particular pattern may be justified based on individual conditions, no specific criteria for lock-in will be developed. However, the Department may develop guidelines for purposes of uniformity. The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over utilization is identified. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers: (3-30-07)

01. Unnecessary Use of Providers or Services. Unnecessary use of providers or Medicaid services, including excessive provider visits. (3-30-07)

02. Demonstrated Abusive Patterns. Recommendation from a medical professional or the participant's primary care physician that the participant has demonstrated abusive patterns and would benefit from the lock-in program. (3-30-07)

03. Use of Emergency Room Facilities. Frequent use of emergency room facilities for non-emergent conditions. (3-30-07)

04. Multiple Providers. Use of multiple providers. (3-30-07)

05. Controlled Substances. Use of multiple controlled substances. (3-30-07)

06. Prescribing Physicians or Pharmacies. Use of multiple prescribing physicians or pharmacies, or both. (3-20-20)

07. Prescription Drugs and Therapeutic Classes. Overlapping prescription drugs with the same therapeutic class. (3-30-07)

08. Drug Abuse. Diagnosis of drug abuse or drug withdrawal, or both. (3-30-07)

09. Drug Behavior. Drug-seeking behavior as identified by a medical professional. (3-30-07)

10. Other Abusive Utilization. Use of drugs or other Medicaid services determined to be abusive by the Department's medical or pharmacy consultant. (3-30-07)

914. LOCK-IN PARTICIPANT NOTIFICATION.
A participant who has been designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing. (3-30-07)

915. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to contact the Regional Program Manager or designee and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. (3-30-07)

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid

appeal is noted in accordance with Section 917 of these rules. (3-30-07)

03. Lock-In Duration. The Department will restrict participants to their designated providers for a time period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. (3-30-07)

04. Payment to Providers. Payment to provider(s) other than the designated lock-in physician or pharmacy is limited to documented emergencies or written referrals from the primary physician. (3-30-07)

05. Regional Programs Manager. The Regional Programs Manager, or designee will: (3-30-07)

a. Clearly describe the participant's appeal rights in accordance with the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings"; (3-30-07)

b. Specify the effective date and length of the restriction; (3-30-07)

c. Have the participant choose a designated provider or providers; and (3-30-07)

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated provider(s). (3-30-07)

916. PENALTIES FOR LOCK-IN NONCOMPLIANCE.
If a participant fails to respond to the notification of medical restriction(s), fails to sign the lock-in agreement, or fails to select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. (3-20-20)

917. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed in accordance with the fair hearings provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," of the Department. (3-30-07)

918. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Monthly Surveys. The Department will conduct monthly surveys of services rendered to medical assistance participants using REOMBs. (3-30-07)

02. Participant Response. A medical assistance participant is required to respond to the Department's explanation of medical benefits survey whenever they are aware of discrepancies. (3-30-07)

03. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on their behalf. (3-30-07)

04. Medicare-to-Medicaid Cross-Over Claims. All claims processed through the cross-over system will be subject to these rules. All providers submitting cross-over claims must comply with the terms of their provider agreements. (3-30-07)

919. -- 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	
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	

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
		TOTAL SCORE:_____

Scoring Definitions:

a. 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.

b. Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.

c. Missing teeth count as 1, if the space is still present.

d. Do not score teeth that are not fully erupted.

e. Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

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